DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

Christopher Kenny, Partner
King & Spalding, LLP
1700 Pennsylvania Avenue NW, Suite 200
Washington, DC 20006-4706

RE: ***Board Jurisdictional Determination***

Ascension Health CY 2018 Section 1115 Waiver Days Florida CIRP Group
Case Number: 22-0833GC

Specifically, as a participant:
Ascension Sacred Heart Gulf (Provider Number 10-0313)

Dear Mr. Kenny:

The Provider Reimbursement Review Board (the "Board") has reviewed the above-captioned common issue related party ("CIRP") group in response to your August 24, 2026 correspondence. The Board finds an impediment related to the group for which the pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

On **February 18, 2022**, King & Spalding, LLP ("K&S") filed a group on behalf of Ascension Health for the Florida Section 1115 Waiver Days issue for calendar year ("CY") 2018. The group was established in the Office of Hearings Case and Document Management System ("OH CDMS") with one provider which was directly added to the group from a Notice of Program Reimbursement ("NPR"):

- Sacred Heart Hospital on the Gulf (a.k.a. "Ascension Sacred Heart Gulf"/Prov. No. 10-0313)

Ascension Sacred Heart Gulf listed a reimbursement impact of $8,052.

On **August 24, 2026**, K&S advised that Case No. 22-0833GC was fully formed but included only one hospital. Therefore, K&S requested that the Board transfer the Provider to a newly formed individual appeal. According to K&S' correspondence, there are currently no open (or closed) CIRP or Non-CIRP groups that are pending for the Florida Section 1115 Waiver Days issue, nor is there a pending individual appeal for the provider.

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the contractor's final determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The regulation at 42 C.F.R. § 405.1837(b)(1) addresses mandatory groups, and includes examples of how certain group situations are handled. Specifically, in (b)(1)(iv)(B), the example reads:

> (B) Example 2: A, B and C are commonly owned providers that wish to appeal issue X. This issue was adjusted on A, B and C's CY 2004 cost reports. The amount in controversy is less than $50,000 in the aggregate for providers A, B and C ($10,000 for A, $10,000 for B and $7,000 for C). Providers A, B and C cannot appeal issue X as a group appeal. Provider A, if it wishes, and provider B, if it wishes, may pursue an individual appeal to the Board under the procedures set forth in §405.1835 of this subpart. **Provider C may not pursue an individual appeal to the Board, because the amount in controversy is less than $10,000; however, it may pursue an appeal to the contractor under the procedures set forth in §405.1811 of this subpart**.[1]

The Board has reviewed 42 C.F.R. § 405.1837(e)(5)(ii) which discusses exceptions to the general rule prohibiting a provider from transferring an issue out of a group appeal once it has elected to form or join one. The exception allows for a provider to request, and for the Board to permit, an issue to be transferred from a group appeal back to a single provider appeal pursuant to §§ 405.1811 or 405.1835, but only when the Board determines that the formal requirements for a group appeal have not been met AND provided the Provider meets the requirements for a single provider appeal. In this situation, Ascension Sacred Heart Gulf has identified a reimbursement impact of $8,052. Therefore, it does not meet the minimum amount in controversy requirement for an individual appeal set forth at § 405.1835(a)(2), which states the reimbursement impact must be $10,000 or more. Thus, the Provider cannot be transferred to an individual appeal. In addition, the Board has searched its database and agrees with K&S' assessment that there are no related CIRP groups for the Florida Section 1115 Waiver Days issue for earlier or later years that could be expanded for this Provider to join.

Consequently, the Board finds the group appeal under Case No. 22-0833GC, which includes only a single provider, must be dismissed, pursuant to 42 C.F.R. § 405.1837(b) and (e)(5)(i) – (ii). Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

The Provider *may* be entitled to appeal rights with the Medicare Contractor pursuant to 42 C.F.R. §§ 405.1809 and 405.1811.

Board Members:
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.
Clayton J. Nix, Esq.

For the Board:

9/1/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: KEVIN D. SMITH -A

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Geoff Pike, First Coast Service Options, Inc. c/o GuideWell Source (J-N)

[1] Bold and underline emphasis added.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

Jeffrey Perlman
Northwell Health
972 Brush Hollow Road, 5th Floor Fin
Westbury, NY 11590

RE: ***Notice of Dismissal***
Northwell Hospital Glen Cove (Provider Number 33-0181)
FYE: 12/31/2018
Case Number: 22-1483

Dear Mr. Perlman:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 22-1483. Set forth below is the decision of the Board regarding the remaining issue in this appeal challenging the Medicare Bad Debts issue.

Background:

A. *Procedural History for Case No. 22-1483*

On **April 1, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2018.

On **September 23, 2022**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained one (1) issue:

1. Medicare Bad Debt

On **September 23, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating

> how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 25.[1]

On **May 18, 2023**, the Provider timely filed its preliminary position paper.

On **September 8, 2023**, the Medicare Contractor timely filed its preliminary position paper.

On **July 6, 2026**, the Medicare Contractor filed a Motion to Dismiss with the Board requesting that the Board dismiss the appeal. Pursuant to Board Rule 44.3, the Provider had 30 days in which to file a response to the Medicare Contractor's Motion. However, to date, the Provider has ***failed*** to file any response.

B. Description of the Issue in the Appeal Request and the Provider's Preliminary Position Paper

In their Individual Appeal Request, the Provider summarizes the appealed issue as follows:

> **Brief Description of Issue – Medicare Bad Debt.**
>
> Glen Cove Hospital[2] wishes to appeal the disallowance of the Medicare Bad Debts on Worksheet E – Part A. Line 64. We disagree with the statement "The provider wrote-off a portion of the amount owed to a charity care account and not a bad debt account, and did not net this adjustment from the total Medicare deductible/coinsurance".
>
> . . .
>
> **Statement Identifying the Legal Basis for the Appeal:-** The provider filed the Bad Debts in accordance with CMS Pub 15-I, Chapter 3 and 42 CFR 413.89.[3]

In the Provider's preliminary position paper in this appeal, filed on May 18, 2023, the narrative is identical to the above issue statement.

MAC's Contentions

In their Motion to Dismiss, the Medicare Contractor "respectfully requests that the Board make the following findings and enter an Order providing as follows:

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[1] (Bold, italics and underline emphasis added).
[2] Note: The Provider is now known as Northwell Hospital Glen Cove.
[3] Issue Statement at 1 (Sept. 23, 2022).

a. That the Provider's Position Paper does not conform to the position paper requirements established by the Board (PRRB Rule 25). Specifically, it consists only of the statement of the issue—similar to the issue statement included in its appeal request—and fails to fully brief its position as to why it believes the MAC's adjustments were improper.

b. That the Provider has failed to furnish documentation in support of its claim for the Medicare Bad Debt issue or describe why such documentation was and continues to be unavailable.

c. That the Provider's failure to furnish such documentation (or describe why such documentation is unavailable) is in violation of PRRB Rules 7, 25.2.1 and 25.2.2. As a result, the Provider has failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper in violation of PRRB Rule 25.3.

d. That the Provider has effectively abandoned its claim for the allowance of the disallowed Medicare Bad Debt on Worksheet E Part A, Line 64.

e. That the Provider's claim for allowance of the disallowed Medicare Bad Debt on Worksheet E Part A, Line 64 is therefore dismissed.[4]

Provider's Response

The Board Rules require that responses to Motions must be filed within thirty (30) days of the filing of the Motion.[5] Board Rule 44.3 specifies: "Unless the Board imposes a different deadline, an opposing party may file a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party." The Provider has not filed a response to the Motion to Dismiss and the time for doing so has elapsed.

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Availability of Issue-Related Information and Basis of Dissatisfaction) states:

[4] Medicare Administrative Contractor's Motion to Dismiss at 5-6 (Jul. 6, 2026).
[5] Board Rule 44.3, v. 3.2 (Dec. 2023).

> The provider must support the determination being appealed and the basis for its dissatisfaction for ***each*** issue under appeal consistent with 42 C.F.R. § 405.1835(b) or (d) as applicable. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions.[6]

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Board Rule 25 requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

[6] (Bold emphasis added.)

Rule 25 Preliminary Position Papers[7]

> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will issue a notice setting deadlines for the first position paper generally at eight months after filing the appeal request for the provider, and twelve months for the Medicare contractor…Therefore, the Board requires preliminary position papers to present the ***fully-*** developed positions of the parties and expects that parties will be diligent in planning and conducting any required investigation, discovery, and analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the applicable sub-section.

25.1.1 Provider's Position Paper

The provider's preliminary position paper must:

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
B. For ***each*** issue that has not been fully resolved, provide a ***fully*** developed narrative that:
    - States the material facts that support the provider's claim.
    - Identifies the controlling authority (*e.g.*, statutes, regulations, policy, or case law) supporting the provider's position.
    - Provides a conclusion applying the material facts to the controlling authorities.
C. Comply with Rule 25.2 addressing Exhibits.

. . .

[7] (Underline emphasis added to these excerpts and all other emphasis in original.)

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, then provide the following information in the position papers:

1. Identify the missing documents;
2. Explain why the documents remain unavailable;
3. State the efforts made to obtain the documents; and
4. Explain when the documents will be available.

Once the documents become available, promptly forward them to the Board and the opposing party….

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to the Board

The Board requires the parties file a ***complete*** preliminary position paper that includes a fully developed narrative (Rule 25.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn.

> **COMMENTARY**: Note that the change to require filing of the ***complete*** preliminary position paper was effective on August 29, 2018. Accordingly, failure to file a ***complete*** preliminary position paper with the Board will result in the Board dismissing your appeal or taking other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on September 23, 2022 included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

As stated above, the Board Rules are clear what must be included in the preliminary position paper (including any exhibits) and Rule 5.2 makes clear representatives must be familiar with Board Rules. In this case, the representative should be familiar as they have filed multiple appeals and appeared before the Board since at least January of 2016.

The Board's rules on the content of position papers and the submission of exhibits with those position papers are consistent with 405.1853(b)(2)-(3). The Board concurs with the Medicare Contractor that the Provider is required to identify the material facts and provide relevant supporting documentation, consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims. The Board finds that the Provider also failed to fully develop the merits of the issue because the provider has failed to file a substantive position paper.

In its Motion to Dismiss, the Medicare Contractor asserts that the Provider has failed to provide a preliminary position paper that identified "why it believes the MAC's adjustments were improper. There are no additional statements of fact, details, arguments, or conclusions."[8] The Board finds there is no dispute to consider as the preliminary position paper failed to develop the issue (no discussion or exhibits addressing the substance) and, instead, simply restated, verbatim, the issue statement. The preliminary position paper doesn't even technically meet the issue requirements in 42 C.F.R. 405.1835(b)(2) as it does not include "a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final contractor . . . determination under appeal, including an account of all of the following:

> (i) Why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item. . . ."

Lastly, pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion to Dismiss. However, the Provider ***failed*** to timely respond by the August 5, 2026 filing deadline (*i.e.*, 30 days after July 6, 2026).

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to identifying the material facts in dispute and the timely submission of documentary evidence required to support its claims or to describe why said evidence is unavailable. Therefore, the Board finds the issue has been abandoned, and is, therefore, dismissed.

* * * * *

In summary, the Board has dismissed the sole issue on appeal. As no issues remain, the case is now closed.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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[8] Motion to Dismiss at ¶ 10.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.
Clayton J. Nix, Esq.

For the Board:

9/2/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: KEVIN D. SMITH -A

cc: Danelle Decker, National Government Services, Inc. (J-K)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran, President
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Board Decision – Dismissal of DSH Payment/SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues***
Northwest Mississippi Regional Medical Center (Prov. No. 25-0042), FYE 12/31/2018
Case No. 23-0487

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-0487. Set forth below is the background of the case and the Board's decision related to the issues challenging the SSI-Provider Specific and Medicaid Eligible Days issues.

Background:

A. ***Procedural History for Case No. 23-0487***

On **July 18, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2018.

On **January 10, 2023**, Community Health Systems ("CHS") filed an appeal on behalf of the Provider. The Appeal Request included five (5) issues:

1. SSI - Provider Specific
2. SSI - Unduly Narrow Definition of SSI Entitlement[1]
3. Medicaid Eligible Days
4. Medicare Managed Care Part C - SSI & Medicaid Fractions[2]
5. Dual Eligible Days - SSI and Medicaid Fractions[3]

The Provider is commonly owned by CHS, so it is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1).

[1] On August 7, 2023, CHS transferred this issue to an SSI Systemic Errors CIRP Group, Case No. 21-1206GC. On August 7, 2026, the Board subsequently denied the transfer because it determined the issues were not the same. On August 12, 2026, QRS transferred the issue to a new Unduly Narrow CIRP group under Case No. 26-2711GC.
[2] On August 7, 2023, this issue was transferred to Case No. 20-2149GC.
[3] On August 7, 2023, this issue was transferred to Case No. 21-0066GC.

On **January 10, 2023**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates ("ACDD"), providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter* "PPP".) This Notice also gave the following instructions to the Provider regarding the content of its PPP:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[4]

On **August 9, 2023**, CHS filed the Provider's PPP.

On **October 30, 2023**, the Medicare Contractor ("MAC") uploaded a copy of its request to the Provider for DSH Medicaid Eligible Days support.

On **December 15, 2023**, the MAC filed a substantive claim challenge.

On **December 18, 2023**, the MAC filed a jurisdictional challenge over the SSI - Provider Specific and Medicaid Eligible Days issues.

On **December 22, 2023,** the MAC filed its PPP.

On **February 6, 2026**, the case was scheduled for a hearing on September 17, 2026.

On **August 11, 2026,** CHS filed a change in representation to Quality Reimbursement Services, Inc. ("QRS") which the Board acknowledged the same day.

B. Description of Issue 1 in the Appeal Request

In its Individual Appeal Request, the Provider summarizes its SSI Percentage (Provider Specific) issue as follows:

> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.

[4] (Emphasis added.)

> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator'. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[5]

On August 9, 2023, the Board received the Provider's PPP in Case No. 23-0487. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the

[5] Issue Statement at 1.

> Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[6]

The amount in controversy listed for both Issue 1 and 2 in the Provider's individual appeal request is $5,305.

Description of Issue 3 in the Appeal Request

In its Individual Appeal Request, the Provider questions whether the MAC properly excluded Medicaid eligible days from the DSH calculation. The Statement of the Legal Basis is as follows:

> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 6, 7, S-D
> Estimated Reimbursement Amount: $17,485

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[7] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[8]

The Provider then, for the first time in this appeal, states it is seeking reimbursement for section 1115 waiver days as a part of the Medicaid eligible day issue. Specifically, the Provider states:

> [M]edicaid eligible days (including section 1115 waiver days (where applicable), which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the

[6] Provider's PPP at 7-8.
[7] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[8] Provider's PPP at 8.

> numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days where applicable).[9]

MAC's Contentions: Issue 1 – DSH SSI Provider Specific

In its jurisdictional challenge, the MAC argues that the Board lacks jurisdiction over the SSI-Provider Specific issue, which has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the sub-issue related to SSI entitlement should be dismissed because it is duplicative of the SSI entitlement issue under appeal in the CIRP group.[10] The component related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies. The MAC asserts the SSI data accuracy portion of the issue should be dismissed because the Provider did not file a complete PPP in accordance with 42 C.F.R. § 405.1853 and Board Rule 25.[11]

MAC's Contentions: Issue 3 – DSH Medicaid Eligible Days

The MAC also argues the Board lacks jurisdiction over the Medicaid Eligible Days issue. The MAC contends that the Provider failed to include a list of additional Medicaid eligible days they expect to be included with their appeal or their PPP, even though the Provider advised that it would send a listing of additional Medicaid eligible days under separate cover. The MAC also challenges the Provider's attempt to untimely add the Section 1115 Waiver Days issue by including it in the narrative of the PPP.[12] Finally, the MAC argues the Provider has abandoned the issue because it failed to sufficiently develop and set forth the relevant facts and arguments in its PPP and because it neglected to include all supporting documentation.[13]

Provider's Jurisdictional Response

Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."[14] The Provider failed to file a timely response by the *January 17, 2024* deadline.

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[9] *Id.* at 8-9.
[10] The Unduly Narrow Definition of SSI Entitlement issue was ultimately transferred to Case No. 26-2711GC.
[11] MAC Jurisdiction Challenge at 2.
[12] *Id.* at 10.
[13] *Id.* at 11 - 13.
[14] Board Rule 44.4.3, v. 3.1 (Nov. 2021).

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby dismisses the Provider's Issue Nos. 1 and 3.

A. SSI Percentage (Provider Specific)

The analysis for Issue No. 1 has two relevant aspects to consider: (1) the Provider's disagreement with how the MAC computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

The aspect of Issue No. 1 related to the Provider's disagreement with how the MAC computed the SSI percentage because of CMS' policy of excluding patients that were entitled to SSI from the numerator of the Medicare fraction—is duplicative of the Unduly Narrow Definition of SSI Entitlement issue that is being pursued as Issue #2.

The SSI- Provider Specific issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[15] Per the appeal request, the Provider's legal basis for its SSI Percentage (Provider Specific) issue asserts that the MAC "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[16] The Provider argues that "its'[sic] SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[17] Finally, the Provider argues that CMS inconsistently interprets the term "entitled" as used in the statute because it requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. "CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days yet refuses to include patient days associated with individuals that were "eligible" for SSI

[15] Issue Statement at 1.
[16] *Id.*
[17] *Id.*

but did not receive an SSI payment." These arguments are restated in Issue No. 2 where the Provider points to CMS' policy of applying different interpretations to the term "entitled."[18]

The Board finds that aspect of the issue related to the term "entitled" in Case No. 23-0487 are duplicative of the Unduly Narrow issue described at Issue No. 2, which was subsequently transferred to a CIRP group, Case No. 26-2711GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[19], the Board dismisses this aspect of the SSI - Provider Specific issue.

Additionally, with regard to the data accuracy aspect of the issue, the Board finds that the Provider's PPP failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of any alleged "errors" in its PPP and include *all* exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents[20]**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[21]

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule:

> Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MEDPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year,*

[18] Issue Statement at 2.
[19] PRRB Rules v. 3.1 (Nov. 2021).
[20] PRRB Rules v. 3.1 (Nov. 2021)
[21] (Italics and underline emphasis added.)

> *for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[22]

Additionally, in its PPP, the Provider states, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra [sic] (Appellants' reply brief included as Exhibit P-3)." The Board finds that this incorporation by reference does not comply with the regulatory and Board rule requirements to *fully* develop the Provider's position in the PPP. Particularly 42 C.F.R. § 405.1853 provides in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[23]

An incorporation of arguments by reference from a different case simply fails to do so. Accordingly, the Board dismisses that portion of the issue as well.

2. Second Aspect of Issue 1

The second aspect of the SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal

[22] Last updated July 31, 2026.
[23] (Emphasis added).

year, it must furnish to CMS, through its intermediary, a written request . . . ." Moreover, without this written request, the MAC cannot issue a final determination with which the Provider can be dissatisfied for Board appeal purposes. There is nothing in the record to indicate the MAC has made a final determination regarding DSH SSI Percentage realignment. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

B. DSH Payment – Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider's issue statement for Issue 3 is stated, *supra*.

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days that affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii), which places the burden of production on the provider states in pertinent part:

> The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) states:

> The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

Furthermore, 42 C.F.R. § 405.1853 addresses position papers and specifies in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[24]

Similarly, with regard to position papers,[25] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[26] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides instruction on the content of position papers as it relates to unavailable documentation/exhibits, as discussed *supra*.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's ***own motion***:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned;
- upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868);
- if the Board is unable to contact the provider or representative at the last known address; or
- upon failure to appear for a scheduled hearing.

Relative to a Medicaid Eligible Days determination, it is well-established that adequate data to prove eligibility for each Medicaid patient day claimed is a complete and accurate (i.e., auditable) Medicaid eligible days listing, which upon timely submission by a provider, a MAC can examine to make applicable adjustments.

This appeal was initiated on January 10, 2023 (more than 3.5 years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expect to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Provider's PPP indicated that it would be sending the eligibility listing under separate cover.[27] ***To-date, no listing has been provided.*** Accordingly, the Provider has abandoned the issue by failing

[24] (Emphasis added).
[25] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for PPPs. *See* Board Rule 27.2.
[26] (Emphasis added).
[27] Provider's PPP at 9.

to properly develop its arguments and provide supporting documents, and by failing to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[28] Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.

C. 1115 Waiver Days

The Board finds that the Section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the Section 1115 Waiver days.

The regulations in effect when this appeal was filed with the Board in January of 2023 required the following:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing in the manner prescribed by the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.[29]

Board Rule 7.2.1 elaborated on this regulatory requirement, instructing providers:

The following information and supporting documentation must be submitted for each issue raised in the appeal request.

- An issue title and a concise issue statement describing:
  - the relevant adjustment(s), including the adjustment number(s),

[28] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.
[29] 42 C.F.R. § 405.1835(b).

- the controlling authority (*e.g.*, specific regulation, Federal Register issuance, manual provision, or Ruling),
- why the adjustment(s) is incorrect,
- how the payment should be determined differently,
- the reimbursement effect, and
- the basis for jurisdiction before the Board.

Board Rule 8 explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these examples are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[30]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[31]

42 C.F.R. § 405.1835(e) provides in relevant part:

> (e) Adding issues to the hearing request. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
>
> . . .
>
> (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

In practice, this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider added the Section 1115 Waiver days to the case properly or timely.

In this regard, the Board notes that Section 1115 Waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[32] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to

[30] (Bold and italic emphasis added).
[31] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[32] 65 FR 47054, 47087 (Aug. 1, 2000).

Section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program and not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) states in pertinent part:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.**
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for **each** Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Because the Provider did not raise the Section 1115 Waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The DSH Medicaid Eligible Days issue as stated in the original appeal request cannot be construed to include Section 1115 Waiver days. Additionally, there is no indication that any 1115 Waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

Finally, even in the Provider's PPP, the Provider fails to identify what § 1115 Waiver program(s) are involved and whether or not the § 1115 Waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(4)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being]

eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the PPP is perfunctory in that it only makes perfunctory conclusions. Again, the Provider failed to so develop its position paper notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Nov. 2021) as applied via Board Rule 27.2.

The Board's finding that neither the appeal request nor the PPP met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[33] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[34] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[35] The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[36] Here, the Board makes the same finding based on similarly *overly generalized language.*

****

Based on the foregoing, the Board is dismissing the SSI - Provider Specific - Issue No.1 and Medicaid Eligible Days (*including Section 1115 Waiver Days*)- Issue No. 3 from this case. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.
Clayton J. Nix, Esq.

For the Board:

9/3/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson C. Leong, Esq., Federal Specialized Services

[33] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[34] *Id*. at *11.
[35] *Id.*
[36] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Baltimore, MD 21244
410-786-2671

September 8, 2026

Daniel Hettich
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Byron Lamprecht
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WPS Government Health Administrators (J-8)
1000 N 90th Street, Suite 302
Omaha, NE 68114-2708

RE: Dismissal of CIRP Group
Henry Ford Health CY 2015 DGME Part C CIRP Group.
PRRB Case Number: 19-1841GC

Dear Mr. Hettich and Mr. Lamprecht:

The Provider Reimbursement Review Board (the "Board") has reviewed the subject group appeal which has not yet been designated to be complete. Upon review, the Board notes that King & Spalding, LLP ("K&S") filed correspondence on June 23, 2025 which indicated the two participants in the common issue related party ("CIRP") group, Henry Ford Macomb Hospital (23-0047) & Henry Ford Allegiance Health (23-0092) are no longer pursuing the DGME Part C issue because the MAC has issued revised Notices of Program Reimbursement ("RNPRs") addressing the issue. K&S requested, however, that the Board allow the group to remain pending because there is another related provider, Henry Ford Hospital (Prov. No. 23-0053), that has not yet received its NPR for its CY 2015. K&S indicated that Henry Ford Hospital is waiting for the MAC to act on Change Request 12596 and that if the MAC fails to adjust the cost report as required by the Change Request, K&S contends that CIRP rules would prohibit Henry Ford from filing an appeal on this issue.

DETERMINATION:

Pursuant to 42 U.S.C. §1395oo(a) and 42 C.F.R. §§405.1835-405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the contractor's final determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination.

The Board is bound by the statutes and regulations, including 42 C.F.R. § 405.1837(b)(1) and Board Rule 12.6.1, which provide that a single provider under common ownership or control may initiate a Common Issue Related Party ("CIRP") group, but at least two different providers must be in the group upon full formation. In this case, K&S has indicated that there is only one more related Provider that may potentially be added to the group and that the originating participants are no longer pursuing the issue. Based on these facts, the Board dismisses Case No. 19-1841GC for failing to meet the minimum participant requirements for a CIRP group. Even if Henry Ford Hospital were to receive its final determination and were added to the group, the group would still include only include a single participant.

Should the MAC fail to adjust the cost report for Henry Ford Hospital, the Provider could file an individual appeal pursuant to § 405.1835(a)(2), provided the reimbursement impact is $10,000 or more.

Board Members Participating:
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.
Clayton J. Nix, Esq.

FOR THE BOARD:



Kevin D. Smith, CPA
PRRB Chair

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: Dismissal of CIRP Group
Henry Ford Health CY 2016 DGME Part C CIRP Group.
PRRB Case Number: 20-1476GC

Dear Mr. Hettich and Mr. Lamprecht:

The Provider Reimbursement Review Board (the "Board") has reviewed the subject group appeal which has not yet been designated to be complete. Upon review, the Board notes that King & Spalding, LLP ("K&S") filed correspondence on June 23, 2025 which indicated the sole provider in the common issue related party ("CIRP") group, Henry Ford Allegiance Health (Prov. No. 23-0092) was no longer pursuing the DGME Part C issue because the Medicare Contractor ("MAC") had issued a revised Notice of Program Reimbursement ("RNPR") addressing the issue. K&S requested, however, that the Board allow the group to remain pending because there is another related provider, Henry Ford Hospital (Prov. No. 23-0053), that has not yet received its NPR for its CY 2016. K&S indicated that Henry Ford Hospital is waiting for the MAC to act on Change Request 12596 and that if the MAC fails to adjust the cost report as required by the Change Request, K&S contends that CIRP rules would prohibit Henry Ford from filing an appeal on this issue.

DETERMINATION:

Pursuant to 42 U.S.C. §1395oo(a) and 42 C.F.R. §§405.1835-405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the contractor's final determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination.

The Board is bound by the statutes and regulations, including 42 C.F.R. § 405.1837(b)(1) and Board Rule 12.6.1., which provide that a single provider under common ownership or control may initiate a Common Issue Related Party ("CIRP") group, but at least two different providers must be in the group upon full formation. In this case, K&S has indicated that there is only one more related Provider that may potentially be added to the group and that the originating participant is no longer pursuing the issue. Based on these facts, the Board dismisses Case No. 20-1476GC for failing to meet the minimum participant requirements for a CIRP group. Even if Henry Ford Hospital were to receive its final determination and were added to the group, the group would still include only be a single participant.

Should the MAC fail to adjust the cost report for Henry Ford Hospital, the Provider could file an individual appeal pursuant to § 405.1835(a)(2), provided the reimbursement impact is $10,000 or more.

Board Members Participating:
Kevin D. Smith, CPA
Ratina Kelly, CPA
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FOR THE BOARD:



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cc: Wilson C. Leong, Federal Specialized Services

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RE: Dismissal of CIRP Group
Henry Ford Health CY 2014 DGME Part C CIRP Group.
PRRB Case Number: 19-1580GC

Dear Mr. Hettich and Mr. Lamprecht:

The Provider Reimbursement Review Board (the "Board") has reviewed the subject group appeal which has not yet been designated to be complete. Upon review, the Board notes that King & Spalding, LLP ("K&S") filed correspondence on June 6, 2025 which indicated the sole provider in the common issue related party ("CIRP") group, Henry Ford Macomb Hospital (Prov. No. 23-0047) was no longer pursuing the DGME Part C issue because the Medicare Contractor ("MAC") had issued a revised Notice of Program Reimbursement ("RNPR") addressing the issue. K&S requested, however, that the Board allow the group to remain pending because there is another related provider, Henry Ford Hospital (Prov. No. 23-0053), that has not yet received its NPR for its CY2014. K&S indicated that Henry Ford Hospital is waiting for the MAC to act on Change Request 12596 and that if the MAC fails to adjust the cost report as required by the Change Request, K&S contends that CIRP rules would prohibit Henry Ford from filing an appeal on this issue.

DETERMINATION:

Pursuant to 42 U.S.C. §1395oo(a) and 42 C.F.R. §§405.1835-405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the contractor's final determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination.

The Board is bound by the statutes and regulations, including 42 C.F.R. § 405.1837(b)(1) and Board Rule 12.6.1, which provide that a single provider under common ownership or control may initiate a Common Issue Related Party ("CIRP") group, but at least two different providers must be in the group upon full formation. In this case, K&S has indicated that there is only one more related Provider that may potentially be added to the group and that the originating participant is no longer pursuing the issue. Based on these facts, the Board dismisses Case No. 19-1580GC for failing to meet the minimum participant requirements for a CIRP group. Even if Henry Ford Hospital were to receive its final determination and were added to the group, the group would still include only be a single participant.

Should the MAC fail to adjust the cost report for Henry Ford Hospital, the Provider could file an individual appeal pursuant to § 405.1835(a)(2), provided the reimbursement impact is $10,000 or more.

Board Members Participating:
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Via Electronic Delivery

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RE: ***Dismissal of DSH Payment/SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues***

North Okaloosa Medical Center (Provider No. 10-0122), FYE 03/31/2019
Case No. 23-0098

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-0098. Set forth below is the background of the case and the Board's decision related to the issues challenging the SSI-Provider Specific and Medicaid Eligible Days issues.

Background:

A. ***Procedural History for Case No. 23-0098***

On **April 25, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end March 31, 2019.

On **October 18, 2022**, Community Health Systems, Inc. ("CHS") filed the Provider's appeal request. The request included five (5) issues:

1. DSH Pymt/ SSI% (Provider Specific)
2. DSH Pymt/ SSI% (Systemic Errors)[1]
3. DSH Pymt - Medicaid Eligible Days
4. Medicare Managed Care Part C Days – SSI & Medicaid Fraction[2]
5. Dual Eligible Days –SSI & Medicaid Fraction[3]

The Provider is commonly owned by CHS so it is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1).

[1] On May 30, 2023, this issue was transferred to Case No. 22-1031GC. Subsequently on August 16, 2026 the Board denied the transfer because the issue had been miscategorized as SSI Systemic Errors but the issue statement described the Unduly Narrow Definition of SSI Entitlement issue. On August 17, 2026, QRS transferred the issue to an Unduly Narrow CIRP group, Case No. 26-2711GC.
[2] On May 30, 2023, this issue was transferred to Case No. 23-0078GC.
[3] On May 30, 2023, this issue was transferred to Case No. 23-0080GC. The Provider had requested a bifurcation of the issue which was denied on June 26, 2023. The Board found that because the Provider had already transferred the issue to an SSI fraction DE days group -it abandoned the Medicaid fraction aspect of the issue.

On **October 19, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter* "PPP").[4] This Notice also gave the following instructions to the Provider regarding the content of its PPP:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 25.[5]

On **February 8, 2023**, the Medicare Contractor ("MAC") uploaded a copy of its request to the Provider for a DSH package.

On **June 12, 2023**, CHS timely filed the Provider's PPP and on **September 7, 2023**, the Medicare Contractor ("MAC") timely filed its PPP.

On **August 21, 2023**, the MAC filed a jurisdictional challenge over the DSH SSI Provider Specific & Medicaid eligible days issues in the case.

On **August 22, 2023**, CHS requested a change of representation to Quality Reimbursement Services, Inc. ("QRS"), which the Board granted on the same day.

On **November 27, 2023,** QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days" listing in the Office of Hearings Case & Document Management System ("OH CDMS").

On **August 4, 2026**, the Board issued a Notice of Hearing scheduling the case for a hearing on February 27, 2027.

B. Description of Issue 1 in the Individual Appeal Request

In its Individual Appeal Request, the Provider summarizes its DSH SSI Provider Specific issue as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.

[4] On March 21, 2023, an updated Critical Due Dates notice was issued.
[5] (Emphasis added).

> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[6]

On June 12, 2023, the Board received the Provider's PPP in Case No. 23-0098. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' [sic] SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the

[6] Issue Statement at 1.

> Medicare fraction. The [*Provider*] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of *Advocate Christ Medical Center, et al, v Xavier Becerra* (Appellants' reply brief included as Exhibit P-3).[7]

The amount in controversy listed for both the SSI Percentage Provider Specific (Issue 1) and the Unduly Narrow Definition of SSI Entitlement (Issue 2) in the Provider's individual appeal request is $36,562.

C. Description of Issue 3 in the Individual Appeal Request

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations. The Provider describes Issue 3 as:

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 4, 19, 20, S-D
> Estimated Reimbursement Amount: $34,419

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[8] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[9]

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[7] Provider's PPP at 8-9.
[8] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[9] Provider's PPP at 9.

In addition, for the first time, the Provider mentions Section 1115 Waiver days:

> Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its 2019 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[10]

MAC's Contentions: Issue 1 – DSH Percentage (SSI Provider Specific)

In its Jurisdictional Challenge, the MAC argues that the Board lacks jurisdiction over the DSH – SSI Provider Specific issue. The MAC argues that within Issue 1 and Issue 2, the Provider is disputing CMS's policy concerning individuals who are eligible for SSI but did not receive SSI payment. This sub-issue is duplicative of the issue that was transferred to a CIRP group.[11] In addition, the MAC maintains that the data accuracy aspect of the issue should be considered abandoned as the Provider failed to file a complete PPP with all supporting documents. The MAC also noted that there has been no final determination over the realignment making the appeal premature as the Provider has not exhausted all available remedies.[12]

MAC's Contentions: Issue 3 – DSH Medicaid Eligible Days

The MAC argues that the Provider abandoned the Medicaid Eligible Days issue when it failed to properly develop its arguments within the PPP in accordance with Board Rules 25 and 27. Additionally, the Provider failed to provide a list of additional Medicaid eligible days or any other supporting documents and did not provide an explanation for why it could not produce those documents.[13]

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[10] Provider's PPP at 9-10.
[11] The MAC initially referenced the SSI Percentage group to which the issue was transferred (Case No. 22-1031GC), but that transfer was denied on August 14, 2026. Issue 2 was subsequently transferred, on August 17, 2026, to a SSI - Unduly Narrow Definition of SSI Entitlement CIRP group under Case No. 26-2711GC.
[12] MAC's Jurisdictional Challenge at 2.
[13] MAC's Jurisdictional Challenge at 2.

Finally, the MAC challenges the Provider's attempt to improperly and untimely add the Section 1115 Waiver days issue. The MAC contends the 1115 Waiver days issue was not part of the initial appeal request nor was it properly added to the appeal.[14]

Provider's Jurisdictional Response

Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."[15] The Provider failed to file a response by the deadline and the time for doing so elapsed as the deadline was September 20, 2023 (*i.e.,* 30 days after the August 21, 2023 filing).

Analysis and Board Determination:

A. SSI Percentage (Provider Specific)

The analysis for Issue No. 1 has two relevant aspects to consider: (1) the Provider's disagreement with how the MAC computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

The first aspect of Issue No. 1 related to the Provider's disagreement with how the MAC computed the SSI percentage because of CMS' policy of excluding patients that were entitled to SSI from the numerator of the Medicare fraction—is duplicative of the Unduly Narrow Definition of SSI Entitlement issue that is being pursued as Issue #2.

The SSI- Provider Specific issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[16] Per the appeal request, the Provider's legal basis for its SSI Percentage (Provider Specific) issue asserts that the MAC "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[17] The Provider argues that "its'[sic] SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[18] Finally, the Provider argues that CMS inconsistently interprets the term "entitled" as used in the statute because it requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the

[14] *Id* at 2.
[15] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[16] Issue Statement at 1.
[17] *Id.*
[18] *Id.*

denominator. "CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment." These arguments are restated in Issue No. 2 where the Provider points to CMS' policy of applying different interpretations to the tern "entitled."[19]

Thus, the Board finds that this aspect of the issue described as SSI - Provider Specific in Case No. 23-0098 are duplicative of the Unduly Narrow issue described at Issue No. 2, which was ultimately transferred to a CIRP group, Case No. 26-2711GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[20], the Board dismisses this aspect of the SSI - Provider Specific issue.

Additionally, the Board finds that, with regard to the data accuracy component of the issue, the Provider's PPP failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of any alleged "errors" in its PPP and include *all* exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents[21]**
>
> If documents necessary to support your position are still unavailable, . . . *identify* the missing documents; *explain why* the documents remain unavailable; *state the efforts* made to obtain the documents; *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[22]

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule:

> Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MEDPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there

[19] Issue Statement at 2.
[20] PRRB Rules v. 3.1 (Nov. 2021).
[21] PRRB Rules v. 3.1 (Nov. 2021)
[22] (Italics and underline emphasis added.)

> is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[23]

Additionally, in its PPP, the Provider states, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra [sic] (Appellants' reply brief included as Exhibit P-3)." The Board finds that this incorporation by reference does not comply with the regulatory and Board rule requirements to *fully* develop the Provider's position in the PPP. Particularly 42 C.F.R. § 405.1853 provides in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[24]

An incorporation of arguments by reference from a different case simply fails to do so. Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on.

Accordingly, *based on the record before it*, the Board finds that SSI Percentage- Provider Specific issue in the instant appeal includes a duplicative argument of that in the DSH SSI -

[23] Last modified July 31, 2026.
[24] (Emphasis added).

Unduly Narrow Definition of SSI Entitlement issue in the appeal and that the component related to SSI data accuracy was not fully briefed in its PPP. Therefore, the Board dismisses these components of the SSI - Provider Specific issue.

2. Second Aspect of Issue 1

The second aspect of the SSI Percentage (Provider Specific) issue related to the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is also dismissed by the Board.

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Moreover, without this written request, the MAC cannot issue a final determination with which the Provider can be dissatisfied for Board appeal purposes. There is nothing in the record to indicate the MAC has made a final determination regarding DSH SSI Percentage realignment. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

B. DSH Payment – Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider's issue statement for Issue 3 is stated, *supra*.

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days that affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii), which places the burden of production on the provider states in pertinent part:

> The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Availability of Issue-Related Information and Basis for Dissatisfaction) states:

> The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal consisten with 42 C.F.R. 405.1835(b) or (d) as applicable. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

Furthermore, 42 C.F.R. § 405.1853 addresses position papers and specifies in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[25]

Similarly, with regard to position papers,[26] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[27] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides instruction on the content of position papers as it relates to unavailable documentation/exhibits, as discussed *supra*.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's ***own motion***:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned;
- upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868);
- if the Board is unable to contact the provider or representative at the last known address; or
- upon failure to appear for a scheduled hearing.

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[25] (Emphasis added).
[26] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for PPPs. *See* Board Rule 27.2.
[27] (Emphasis added).

Relative to a Medicaid Eligible Days determination, it is well-established that adequate data to prove eligibility for each Medicaid patient day claimed is a complete and accurate (i.e., auditable) Medicaid eligible days listing, which upon timely submission by a provider, a MAC can examine to make applicable adjustments.

This appeal was initiated on October 18, 2022 (almost 4 years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expect to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Provider's PPP indicated that it would be sending the eligibility listing under separate cover.[28]

On November 27, 2023, the Provider submitted a "Supplement to Position Paper/Redacted Medicaid Eligible Days" listing. The 8-page listing showed roughly 1,215 "Additional ME Days" and included the caveat that the "Listing [is] pending finalization upon receipt of State eligibility data." The Provider's filing did not explain why the listing, which included substantially more than the 50 days noted in the initial appeal, was being submitted at that late date or why it was not final despite having been submitted more than four and a half years after the fiscal year at issue had closed. Regardless, this filing was more than five months past the deadline for including it with its PPP since that deadline was June 15, 2023.

The Board concurs with the MAC - that the Provider is required to identify *the material facts* (*i.e.*, the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(4)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board also finds that the Provider failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

The Board rejects the Provider's attempts to include the eligible days listing filed as a supplement on November 23, 2023 because:

1. The upload was filed more than five months *after the deadline* for the exhibits to be included with the PPP filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)).

2. The uploaded exhibit fails to explain the following critical information: (a) *why* it was being filed so late (*i.e.*, upon what basis or authority should the Board accept the late filing); and (b) *why* the listing was not previously available, *in whole or in part* (*i.e.*, it is not clear why the Provider failed to identify a single day at issue until more than 13 months after this appeal was filed and more than four and a half years after the fiscal year at issue had closed).

[28] Provider's PPP at 10.

3. Neither the Board Rules, nor the October 19, 2022 Case Acknowledgment and Critical Due Dates notice, permit the Provider to file a "Supplement" to its PPP (nor did the Provider allege in the final PP that they do).

4. Given that the *material* facts (*e.g.*, the days at issue) and all available exhibits were required to be part of the PPP filing, if the Board were to accept the Exhibit as a "Supplement" to the PPP, it would need to be either be a *refinement* of its PPP or a supplement of documents that were identified in the PPP as being unavailable consistent with Board Rule 25.2.2. However, neither the appeal request, nor the PPP, identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the uploaded listing cannot be considered a refinement of the position paper since no specific days or listing were included with the PPP.[29]

5. Finally, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[30] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the PPP filing (much less provide the § 412.106(b)(4)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

C. 1115 Waiver Days

Additionally, the Board finds that the Section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the Section 1115 Waiver days.

The regulations in effect when this appeal was filed with the Board in February 2023 required the following:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing in the manner prescribed by the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…

[29] *See, e.g.,* Board Rule 27.3 (Nov. 2021) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."
[30] (Emphasis added.)

> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.[31]

Board Rule 7.2.1 elaborated on this regulatory requirement, instructing providers:

The following information and supporting documentation must be submitted for each issue raised in the appeal request.

- An issue title and a concise issue statement describing:
  - the relevant adjustment(s), including the adjustment number(s),
  - the controlling authority (*e.g.*, specific regulation, Federal Register issuance, manual provision, or Ruling),
  - why the adjustment(s) is incorrect,
  - how the payment should be determined differently,
  - the reimbursement effect, and
  - the basis for jurisdiction before the Board.

Board Rule 8 explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these examples are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[32]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[33]

42 C.F.R. § 405.1835(e) provides in relevant part:

> (e) Adding issues to the hearing request. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
> . . .

[31] 42 C.F.R. § 405.1835(b).
[32] (Bold and italic emphasis added).
[33] *See* 73 Fed. Reg. 30190 (May 23, 2008).

> (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

In practice, this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider added the Section 1115 Waiver days to the case properly or timely.

In this regard, the Board notes that Section 1115 Waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[34] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program and not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) states in pertinent part:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.**
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for **each** Medicaid patient day claimed under this

[34] 65 FR 47054, 47087 (Aug. 1, 2000).

> paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Because the Provider did not raise the Section 1115 Waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The DSH Medicaid Eligible Days issue as stated in the original appeal request cannot be construed to include Section 1115 Waiver days. Additionally, there is no indication that any 1115 Waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

Finally, Provider's PPP fails to identify what § 1115 Waiver program(s) are involved and whether or not the § 1115 Waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(4)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the PPP is perfunctory in that it only makes perfunctory conclusions. Again, the Provider failed to so develop its position paper notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Nov. 2021) as applied via Board Rule 27.2.

The Board's finding that neither the appeal request nor the PPP met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[35] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[36] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[37] The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[38] Here, the Board makes the same finding based on similarly *overly generalized language.*

****

Based on the foregoing, the Board is dismissing Issue 1-the SSI Percentage - Provider Specific issue and Issue 3- the Medicaid Eligible Days (*including Section 1115 Waiver Days*) from this case. As there are no remaining issues, Case No. 23-0098 is hereby closed and removed from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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[35] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[36] *Id*. at *11.
[37] *Id.*
[38] *Id.*

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.
Clayton J. Nix, Esq.

For the Board:

9/9/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson C. Leong, Esq., Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
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RE: ***Notice of Dismissal***
Baylor Scott & White Medical Center Centennial, Prov. No. 45-0885, FYE 03/31/2020
Case No. 24-0396

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 24-0396. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 24-0396*

On **June 16, 2023**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end March 31, 2020.

On **December 6, 2023**, Quality Reimbursement Services, Inc. ("QRS") filed an appeal on behalf of the Provider which included five issues[1]:

1. SSI - Provider Specific[2]
2. SSI Unduly Narrow Definition of SSI Entitlement[3]
3. Medicaid Eligible Days
4. SSI MCD Pt C[4]
5. SSI MCD Dual[5]
6. Improper Ruling – Medicaid Fraction Dual Eligible Days[6]

[1] On July 9, 2024, the Board agreed to bifurcate the MCD Dual issue: the SSI Fraction Dual Eligible Days remained at Issue 5 and Issue 6 was created for the Medicaid Fraction Dual Eligible Days issue.
[2] On December 15, 2025, this issue was withdrawn.
[3] On July 22, 2024, this issue was transferred to Case No. 24-1926GC.
[4] On July 22, 2024, this issue was transferred to Case No. 24-1930GC.
[5] On July 22, 2024, this issue was transferred to Case No. 24-1928GC.
[6] On July 22, 2024, this issue was transferred to Case No. 24-1929GC.

The Provider is commonly owned/controlled by Baylor Scott & White Health (hereinafter "BS&W") and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1).

On **December 12, 2023**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter* "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[7]

On **August 2, 2024**, the Provider timely filed its PPP and the Medicare Contractor ("MAC") filed its PPP on **November 22, 2024**.

On **November 24, 2025**, the MAC filed a jurisdiction challenge over the SSI Provider Specific & Medicaid Eligible Days issues. (SSI Provider Specific issue was subsequently withdrawn).

On **December 15, 2025,** the Provider filed a "Redacted Medicaid Eligible Days Listing" in OH CDMS.

On **December 15, 2025,** the Provider timely responded to the MAC's jurisdictional challenge.

Description of Issue 3 in the Appeal Request

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations. The Provider describes Issue 3 as:

> **Statement of Issue**
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the

[7] (Emphasis added.)

> Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[8]

On August 2, 2024, the Provider filed its PPP in which it indicated that it would be sending the eligibility listing under separate cover.[9] The position paper did not identify how many Medicaid eligible days remained in dispute in this case. The following is the Provider's ***complete*** position on Issue 3 set forth therein:

> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106 (b) (4) of the Secretary's Regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v Shalala*, 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp. 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.

[8] Appeal Request at Issue 3.
[9] Provider's PPP at 10.

> Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, including Section 1115 waiver days, the Provider contends that the total number of days reflected in its 2018 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.
>
> With respect to section 1115 waiver days, the courts have firmly rejected CMS's interpretation of its regulations, holding instead that the plain language of the statute and the regulations require inclusion in the Medicaid Fraction of the days belonging to individuals who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool. *See Forrest General Hospital*, 926 F.3d 221 (5th Cir. 2019); *HealthAlliance Hospitals, Inc. v. Azar*, 346 F. Supp. 3d 43(D.D.C. 2018); *Bethesda Health Inc., v. Azar*, 389 F. Supp. 3d 32, (D.D.C. 2019), *aff'd*, 980 F.3d 121 (D.C. Cir. 2020). CMS has acquiesced in *Bethesda* and is now following the statute and the plain meaning of its own regulations (which regulations represent the official policy of CMS all along). *See* CMS Manual Instructions System, Change Request 12669, Transmittal No. 11912 (March 163, 2023) ("Transmittal 11912"), attached as Exhibit P-4.[10]

MAC's Contentions- Issue 3 – DSH – Medicaid Eligible Days

The MAC contends that the Provider failed to properly develop its arguments within its PPP in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rules 25 and 27. The MAC argues the Provider has not submitted an auditable list of Medicaid Eligible days, nor did it explain why it could not produce the documents. Therefore, the MAC considers the issue to have been abandoned and requests the Board dismiss the issue.

[10] Provider's PPP at 9-10.

Additionally, the MAC contends the Provider is attempting to improperly and untimely add the Section 1115 Waiver days issue. The Section 1115 Waiver days were not part of the initial appeal and were not mentioned until the PPP.

Provider's Jurisdictional Response

QRS filed a timely response to the MAC's jurisdiction challenge, but only addressed the challenge over the Section 1115 waiver days sub-issue. QRS argued that:

1. Based on the phrasing of the issue statement, the Provider timely appealed the Medicaid Eligible Days issue. The statement included the following language:

   > The MAC, contrary to the regulation, failed to include all Medicaid eligible days, *including but not limited to* Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation. (Emphasis added.)

   According to QRS, "[b]y definition, section 1115 waiver days are Medicaid eligible days. See 42 C.F.R. § 412.106(b)(4)(i) and (ii)."[11]

2. Regarding the MAC's argument that the Provider abandoned the issue, QRS contends the MAC is required to accept and audit the Provider's section 1115 waiver days per CMS instruction. QRS asserts that it submitted a redacted listing (via upload to OH CDMS portal) and submitted an unredacted version to the MAC on December 15, 2025.[12]

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby ***dismisses*** the Provider's sole remaining issue.

A. DSH Payment – Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider's issue statement for Issue 3 is stated, *supra*.

[11] Jurisdictional Response at 1.
[12] Jurisdictional Response at 3-4.

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days that affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii), which places the burden of production on the provider states in pertinent part:

> The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

With regard to the filing of an individual appeal, Board Rule 7 - Support for Appealed Final Determination, Availability of Issue-Related Information and Basis for Dissatisfaction (Dec. 2023) states:

> The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal consisten with 42 C.F.R. 405.1835(b) or (d) as applicable. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a**

> **timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[13]

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Preliminary position paper requirements are set forth in Board Rule 25 (Nov. 2021). The Rule requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

Rule 25 - Preliminary Position Papers[14]

> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the following sub-sections.

25.1.1 The Provider's Position Paper

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
D. Provide a conclusion applying the material facts to the controlling authorities.

[13] (Bold emphasis added.)
[14] (Underline emphasis added to these excerpts and all other emphasis in original.)

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents
If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to the Board

Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's ***own motion***:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned;
- upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868);
- if the Board is unable to contact the provider or representative at the last known address; or
- upon failure to appear for a scheduled hearing.

Relative to a Medicaid Eligible Days determination, it is well-established that adequate data to prove eligibility for each Medicaid patient day claimed is a complete and accurate (i.e., auditable) Medicaid eligible days listing, which upon timely submission by a provider, a MAC can examine to make applicable adjustments.

This appeal was initiated on December 6, 2023 (more than 2.5 years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expect to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Provider's PPP indicated that it would be sending the eligibility listing under separate cover.[15]

On December 15, 2025, the Provider submitted a "Redacted Medicaid Eligible Days Listing Submission." The 2-page listing showed roughly 190 "Additional ME Days" and included the caveat that the "Listing [is] pending finalization upon receipt of State eligibility data." The Provider's filing did not explain why the listing, which included substantially more than the 100 days noted in the initial appeal, was being submitted at that late date or why it was not final despite having been submitted more than five and a half years after the fiscal year at issue had closed. Regardless, this filing was more than sixteen months past the deadline for including it with its PPP since that deadline was August 2, 2024.

The Board concurs with the MAC - that the Provider is required to identify *the material facts* (*i.e.*, the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(4)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board also finds that the Provider failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

Further, the Board rejects the Provider's attempts to include the eligible days listing filed on December 15, 2025 because:

[15] Provider's PPP at 10.

1. The upload was filed more than sixteen months *after the deadline* for the exhibits to be included with the PPP filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)).

2. The uploaded exhibit fails to explain the following critical information: (a) *why* it was being filed so late (*i.e*., upon what basis or authority should the Board accept the late filing); and (b) *why* the listing was not previously available, *in whole or in part* (*i.e*., it is not clear why the Provider failed to identify a single day at issue until more than 2 years after this appeal was filed and more than five and a half years after the fiscal year at issue had closed).

3. Neither the Board Rules, nor the December 12, 2023 Case Acknowledgment and Critical Due Dates notice, permit the Provider to file a "Supplement" to its PPP.

4. Given that the *material* facts (*e.g*., the days at issue) and all available exhibits were required to be part of the PPP filing, if the Board were to accept the Exhibit as a "Supplement" to the PPP, it would need to be either be a *refinement* of its PPP or a supplement of documents that were identified in the PPP as being unavailable consistent with Board Rule 25.2.2. However, neither the appeal request, nor the PPP, identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the uploaded listing cannot be considered a refinement of the position paper since no specific days or listing were included with the PPP.[16]

5. Finally, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[17] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the PPP filing (much less provide the § 412.106(b)(4)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

B. Section 1115 Waiver Days

The Board also concurs with the MAC that the Section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. While the Provider appealed Medicaid Eligible days, this issue is separate and distinct from the Section 1115 Waiver days.

The appeal was filed with the Board in December 2023 and the regulations required the following:

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[16] *See, e.g.,* Board Rule 27.3 (Nov. 2021) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."
[17] (Emphasis added.)

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[18]

Board Rule 7.2.1 (2021) elaborated on this regulatory requirement, instructing providers:

> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
> - the adjustment, including the adjustment number,
> - the controlling authority,
> - why the adjustment is incorrect,
> - how the payment should be determined differently,
> - the reimbursement effect, and
> - the basis for jurisdiction before the [Board].

Board Rule 8 (Nov.2021) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[19]

[18] 42 C.F.R. § 405.1835(b).
[19] (Bold and italic emphasis added).

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[20]

42 C.F.R. § 405.1835(e) provides in relevant part:

> (e) Adding issues to the hearing request. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
> . . .
> (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

In practice, this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination (*The time-period for adding issues to this case elapsed on February 16, 2024*). However, there is no evidence in the record to indicate the Provider properly or timely added the Section 1115 Waiver days issue to the case. The first mention of the issue was in the PPP filed on August 2, 2024, which was more than five and a half months beyond the deadline to add an issue.

In this regard, the Board notes that Section 1115 Waiver days are not traditional Medicaid Eligible days and, indeed, were only incorporated into the DSH calculation effective January 20, 2000.[21] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying Section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a Section 1115 Waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) (2019) states in pertinent part:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for

[20] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[21] 65 FR 47054, 47087 (Aug. 1, 2000).

> inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.**
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for **each** Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Because the Provider did not raise the Section 1115 Waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The Medicaid Eligible days issue as stated in the original appeal request cannot be construed to include Section 1115 Waiver days. Additionally, there is no indication that any Section 1115 Waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

Regardless, even if the Provider had included in its appeal request (***which it did not***), the Provider failed to properly develop the issue in its PPP filing as it does not identify the specific 1115 Waiver day program(s) at issue). In addition, the PPP does not discuss whether or not the Section 1115 Waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the PPP is perfunctory in that it only makes cursory conclusions.[22] Again, the Provider failed to so develop its PPP, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 23 (Nov. 2021).

As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this

[22] For example, QRS cites to *Forrest General Hosp.*, 926 F.3d 221 (5th Cir. 2019) for the proposition that "the plain language of the statute and regulations require inclusion in the Medicaid Fraction of the days belong to individual who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool." However, QRS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is QRS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? QRS fails to brief the merits of its claims and fails to establish the Board's jurisdiction over the § 1115 waiver day issue as required by 42 C.F.R. § 405.1853(b)(2). Indeed, the quoted sentence is the only time the PPP references "uncompensated care pool."

paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* Section 1115 Waiver days sub-issue.

The Board's finding that neither the appeal request nor the PPP met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[23] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[24] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[25] The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[26] Here, the Board makes the same finding based on similar *overly generalized language.*

* * * * *

Based on the foregoing, the Board dismisses the last remaining issue in this case – Medicaid Eligible days (Issue #3) including Section 1115 Waiver days. As no issues remain, the Board hereby closes Case No. 24-0396 and removes it from the Board's docket.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.
Clayton J. Nix. Esq.

For the Board:

9/9/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-H)
Wilson Leong, FSS

[23] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[24] *Id*. at *11.
[25] *Id.*
[26] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Sven Collins
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999 18th Street
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RE: **Notice of Dismissals**
Case Number: 26-1960G - Hooper Lundy & Bookman CY 2006 Standardized Amt Predicate Fact Err 1986 BNAs Impact on DSH Group
Case Number: 26-1964G - Hooper Lundy & Bookman CY 2007 Standardized Amt Predicate Fact Err 1986 BNAs Impact on DSH Group
Case Number: 26-1968G - Hooper Lundy & Bookman CY 2008 Standardized Amt Predicate Fact Err 1986 BNAs Impact on DSH Group
Case Number: 26-2310G - Hooper Lundy & Bookman CY 2010 Standardized Amount Predicate Fact – 1986 BNA Impact on DSH Group

Dear Mr. Collins:

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the records in the above referenced appeals. The decision of the Board to ***dismiss*** the four (4) group appeals is set forth below.

Procedural history:

These four (4) group appeals were filed between **March and April, 2026** and none of the groups are fully formed. All the participants are appealing from Revised NPRs ("RNPRs"). The "Notice of Reopening" accompanying the RNPRs is the Administrator's Remand Order, as well as Change Request 13294 (Feb. 21, 2024), which was issued to Medicare Contractors "to provide guidance for the treatment of Medicare Part C days in the calculation of a provider's Medicare Disproportionate Share Hospital adjustment."[1] The RNPRs all show a $0 change in Medicare reimbursement and specifically note they were issued as a result of Change Request 13294. The relevant audit adjustments for all group participants are either silent to any substantive adjustment or specifically reference that no updated figures were used to implement Change Request 13294.

None of the issue statements contain any substantive discussion of the RNPRs, audit adjustments, or explain how the Board has jurisdiction over the 1986 budget neutrality adjustment issue from the RNPRs. The appeals concern whether 1985 budget neutrality

[1] CMS Transmittal 12513, Change Request 13294 at 1 (Feb. 21, 2024).

adjustments were unlawfully carried forward to 1986 and beyond, thus impacting present day IPPS rates.[2]

Relevant Law:

A. RNPR Appeals

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2023), which provides, in relevant part:

> (a) General. (1) A Secretary determination, a contractor determination, or a decision by a reviewing entity (as described in § 405.1801(a)) may be reopened, with respect to specific findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the contractor (with respect to contractor determinations), or by the reviewing entity that made the decision. . . .

Additionally, 42 C.F.R. § 405.1889 (2023)[3] explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) ***Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.***
>
> (2) ***Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.***[4]

As outlined above, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[5]

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[2] *E.g.*, Case No. 26-1960G, Issue Statement (Mar. 4, 2026).
[3] *See also Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).
[4] (Bold and italics emphasis added.)
[5] 42 C.F.R. § 405.1889(b)(1).

B. Retroactive Part C Rule, Resulting RNPRs, and Associated Appeal Rights

i. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[6] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[7]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[8] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[9]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[10] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[11] The DPP is defined as the sum of two fractions expressed as percentages.[12] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), defines the Medicare/SSI fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[13]

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[6] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[7] *Id.*
[8] *See* 42 U.S.C. § 1395ww(d)(5).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[12] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[13] (Emphasis added.)

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[14]

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[15]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[16]

ii. Establishment of Medicare Part C and Treatment of Part C Days in the DSH Calculation

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations ("HMOs") and competitive medical plans ("CMPs") is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to an eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A and enrolled under part B . . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days.

In the September 4, 1990 Federal Register, the Secretary[17] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR)

[14] 42 C.F.R. § 412.106(b)(2)-(3).
[15] (Emphasis added.)
[16] 42 C.F.R. § 412.106(b)(4).
[17] of Health and Human Services.

> file that allows us to isolate those HMO days that are associated with Medicare patients. Therefore, since that time we have been including HMO days in SSI/Medicare percentage [of the DSH adjustment].[18]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[19]

With the creation of Medicare Part C in 1997,[20] Medicare beneficiaries who are entitled to Medicare Part A benefits may elect to receive managed care coverage under Medicare Part C, and following that election, the beneficiary's benefits are no longer administered under Medicare Part A.[21] As part of the federal fiscal year ("FFY") 2004 IPPS proposed rule, the Secretary noted she had received "questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation." In response to those questions, the Secretary proposed "to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage" but rather "[t]hese patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[22] The Secretary did not finalize that policy in the FFY 2004 IPPS final rule because the Secretary had not yet completed review of the large number of comments received.[23]

In the FFY 2005 IPPS proposed rule, the Secretary referenced the Part C proposal in the FFY 2004 IPPS proposed rule and stated her intention to address the comments received on that proposal in the FY 2005 IPPS final rule.[24] In the FFY 2005 IPPS final rule, the Secretary purportedly changed her proposal/position by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[25] In response to a comment regarding this change, the Secretary explained that:

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[18] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[19] *Id.*
[20] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015*, codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[21] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[22] *Id.*
[23] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[24] 69 Fed. Reg. 28196, 28286 (May 18, 2004).
[25] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[26]

This statement would require inclusion of Medicare Part C inpatient days in the Medicare fraction of the DSH calculation.

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, it was not codified into the Code of Federal Regulations. The Secretary did not codify the policy change until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[27] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[28] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[29]

There has been substantial litigation over whether enrollees in Part C plans are "entitled to benefits" under Medicare Part A when determining their placement in either the DSH Medicare or Medicaid fraction.

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[26] *Id.* (emphasis added).
[27] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[28] *Id*. at 47411.
[29] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[30]

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[31] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[32] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[33] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for FFYs 2014 and beyond.[34] However, at that point, no new rule had been adopted for FFYs 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the Part C policy adopted in the FFY 2005 IPPS final rule. In 2014 the Secretary published Medicare fractions for FFY 2012 which included Part C days.[35] A number of hospitals appealed this action.[36] In *Azar v. Allina Health Services* ("*Allina II*"),[37] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[38] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[39] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[40]

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[30] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[31] 746 F. 3d 1102 (D.C. Cir. 2014).
[32] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[33] *Id.* at 2011.
[34] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[35] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[36] The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo**(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board, **pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[37] 139 S.Ct. 1804 (2019).
[38] *Id.* at 1817.
[39] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[40] 139 S.Ct. at 1814.

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[41] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[42]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[43] The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[44]

Finally, the following excerpts from the June 9, 2023 Final Rule discussing a hospital's right to challenge the Part C days policy adopted therein make clear that the Secretary did not consider the final rule or subsequent publication of SSI ratios to be an appealable "final determination":

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[41] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[42] CMS Ruling 1739-R at 1-2.
[43] 88 Fed. Reg. 37772 (June 9, 2023).
[44] 88 Fed. Reg. at 37788 (emphasis in original).

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports***. *In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[45]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[46]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised* ***NPRs*** *will provide hospitals with a* ***vehicle to appeal*** *the new final action* even if the Medicare fraction or DSH payment does not change numerically."[47]

4. "*When the Secretary's treatment of Part C days in this final action is reflected* ***in NPRs and revised NPRs****, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation* ***by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[48]

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[45] 88 Fed. Reg. at 37774-75 (emphasis added).
[46] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[47] *Id.* at 37788 (emphasis added).
[48] *Id.* (emphasis added).

The above discussion in the preamble to the June 9, 2023 Final Rule makes clear that hospitals covered by that Final Rule would have appeal rights maturing with the yet-to-be-issued NPRs (original or revised) that would apply the finalized policy.

The Board also notes that, on September 30, 2025, the District Court for the District of Columbia issued a decision holding Part C enrollees are "entitled to [Part A] benefits" within the context of 42 U.S.C.§ 1395ww(d)(5)(F)(vi), even when they elect to receive Part C benefits.[49] It ruled, however, that the June 9, 2023 Final Rule is both impermissible retroactive[50] arbitrary and capricious.[51] The court ordered the parties to submit briefs on the appropriate remedy for the unlawful regulation,[52] and on August 28, 2026, the court vacated the June 9, 2023 Final Rule and remanded the case to the Secretary.[53] The time frame for the government to appeal this decision, however, has not yet elapsed.[54]

Decision of the Board:

A. Issues Appealed from RNPR

42 C.F.R. § 405.1889 governs the scope of appeals once a contractor determination is "reopened as provided in § 405.1885[.]" In this circumstance, Providers have *limited* appeal rights and are only able to appeal issues or matters that were "specifically revised" in the RNPRs.

The appeal rights detailed in the June 9, 2023 Final Rule specifically limit a provider's appeal rights to specific matters related to the actual RNPR (*i.e.*, the Part C Days policy). First, the Secretary made clear that the Part C Days rule could be appealed following the issuance of a new NPR or RNPR "***even if the Medicare fraction or DSH payment does not change numerically.***"[55] Thus, the new rule could be appealed even if the treatment of Part C Days was not "specifically revised."

The appeal rights, however, are strictly limited to the policy related to the treatment of Part C days. Following the issuance of a RNPR, the Secretary stated that Providers "***will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions contained in the NPRs or revised NPRs***[,]" "**will be able to challenge the agency's interpretation** [of the treatment of Part C days in this final action] by appealing those NPRs and revised NPRs[,]" and further stated that they "**can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[56]

[49] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).
[50] *Id.* at *12-19.
[51] *Id.* at *19-22.
[52] *Id.* at *23.
[53] *Montefiore Med. Ctr. v. Kennedy*, 2026 WL 2547056, *14 (D.D.C. 2026).
[54] Fed. R. App. P. 4(a)(1)(B).
[55] 88 Fed. Reg. 37788 (emphasis added).
[56] *Id.* at 37787-88 (emphasis added).

The issue in these group appeals concerns whether 1985 budget neutrality adjustments were unlawfully carried forward to 1986 and beyond, thus impacting present day IPPS rates. The appeal of this issue was taken from RNPRs that were issued specifically to reflect and implement the treatment of Part C days as set forth in the June 23, 2023 Final Rule. The RNPRs make no changes at all to the Providers' payments or cost reports related to this specific issue. The Providers make no effort to demonstrate how these RNPRs or audit adjustments relate to this issue. The Providers make no mention of 42 C.F.R. 405.1889(b)(1), which addresses what may be appealed from an RNPR such as those in these cases. The only appeal rights stem from the 2023 Final Rule, which are specifically tied to the implementation of the new Part C Rule. The Board also notes that none of the Providers in these groups appear to have appealed the budget neutrality adjustment carryforward issue when appealing from their original NPRs, and only seek to pursue this issue from RNPRs that did not make any specific adjustments related to the issue.

Additionally, the Board notes that 42 C.F.R. § 405.1835 addresses the right to a board hearing for individual provider appeals, and in particular, § 405.1835(b) requires the hearing request to demonstrate that the provider satisfies the requirements for a hearing (*i.e.* establish Board jurisdiction) for each item appealed:

> [t]he provider's request for a Board hearing under paragraph (a) of this section . . . ***must*** include the elements described in paragraphs (b)(1) through (4) of this section. . . .
>
> * * *
>
> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific identification of the final contractor or Secretary determination under appeal.[57]

Accordingly, the Board notes that 42 C.F.R. § 405.1835(a)(1) states:

> [t]he provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. ***Exception: If a final contractor determination is reopened under § 405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination*** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).[58]

The right to establish a group is subject to parallel requirements at §§ 405.1837(c) and 405.1837(a)(1) respectively.[59] Further, Board Rule 4.1 (2023) states that "[t]he Board may

[57] 42 C.F.R. § 405.1835(b) (bold and italics emphasis added).
[58] (Bold and italics emphasis added.)
[59] In particular, 42 C.F.R. § 405.1837(c) states, in pertinent part: "The request for a Board hearing as a group appeal must be submitted in writing to the Board, and the request must include all of the following: (1) A demonstration

review jurisdiction on its own motion at any time." Similarly, 42 C.F.R. § 405.1837(e)(2) specifies that "[t]he Board may make jurisdictional findings . . . at any time."[60] In the instant cases the Board has done so, and has determined that the Providers have not met their burden to prove that the Board has jurisdiction, in accordance with the regulations at 42 C.F.R. §§ 405.1835(b)(1), 405,1837(c)(1), and 405.1889(b)(1), in these group appeals.

Conclusion:

The issue in these cases taken from the Providers' RNPRs concerns whether 1985 budget neutrality adjustments were unlawfully carried forward to 1986 and beyond, thus impacting present day IPPS rates. The appeal of this issue was taken from RNPRs that were issued specifically to reflect and implement the treatment of Part C days as set forth in the June 9, 2023 Final Rule. The RNPRs made no changes at all to the Providers' payments or cost report related to the issue under appeal in these cases. The Providers make no effort to demonstrate how these RNPRs or audit adjustments relate to this issue to establish the Board's jurisdiction over these appeals notwithstanding their obligation to do so under 42 C.F.R. §§ 405.1835(b) and 405.1837(c).

The Board has reviewed the record in these cases and finds that (1) the RNPRs did not make "specific revisions" related to whether 1985 budget neutrality adjustments were unlawfully carried forward to 1986 and beyond, thus impacting present day IPPS rates and, as a result, pursuant to 42 C.F.R. § 405.1889(b)(1), that issue is beyond the scope of any appeal from the RNPRs, and (2) the only appeal rights afforded from the RNPRs as set forth in the June 9, 2023 Final Rule are to challenge the treatment of Part C Days in the RNPRs. Based on the foregoing, the Board is hereby ***dismissing*** Case Nos. 26-1960G, 26-1964G, 26-1968G, and 26-2310G.[61]

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section."

[60] The only specified limitation is that the Board may not dismiss a group for failure to meet the amount in controversy requirement until after the group is fully formed.

[61] The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. §405.1889(b). *See, e.g., HCA Health Servs. of Okla. v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994); *McLaren Flint v. Azar*, 464 F. Supp. 3d 1 (D.D.C. 2020); *St. Mary's of Mich. v. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *Franciscan St. Margaret Health v. Azar*, 407 F. Supp. 3d 28 (D.D.C. 2019); *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *Illinois-Masonic Med. Ctr. v. Sebelius*, 859 F. Supp. 2d 137 (D.D.C. 2012).

Board Members:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq. (abstaining)[62]
Shakeba DuBose, Esq.
Clayton J. Nix, Esq.

For the Board:

9/10/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: KEVIN D. SMITH -A

cc: Wilson Leong, Esq. Federal Specialized Services
Dana Johnson, Palmetto GBA c/o Wellpoint Federal Solutions, Inc. (J-M)
Cecilia Lukito, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Syrie Cauthen, Wellpoint Federal Solutions, Inc. (J-6)

[62] Board Member Musgrave declines to render an opinion on this matter. It is her contention that the Medicare Contractor has a responsibility to make its own legal and factual argument supporting a jurisdictional challenge (Board Rule 44.1) and that the Providers should be given the opportunity to file responses (Board Rule 44.3). She acknowledges that the Board may review jurisdiction on its own motion at any time (Board Rule 4.1). However, rather than forestall the Medicare Contractor's challenge with the Board's "Own Motion" determination, she would prefer that the Board instead allow the parties to present their own positions.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Sven Collins
Hooper, Lundy & Bookman, P.C.
999 18th Street
Suite 3000
Denver, CO 80202

RE: **Notice of Dismissals**
Case Number: 26-1961G - Hooper Lundy & Bookman CY 2006 Standardized Amount Base Rate Accuracy Impact on DSH Group
Case Number: 26-1965G - Hooper Lundy & Bookman CY 2007 Standardized Amount Base Rate Accuracy Impact on DSH Group
Case Number: 26-1969G - Hooper Lundy & Bookman CY 2008 Standardized Amount Base Rate Accuracy Impact on DSH Group

Dear Mr. Collins:

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the records in the above referenced appeals. The decision of the Board to ***dismiss*** the three (3) group appeals is set forth below.

Procedural history:

These three (3) group appeals were filed **March 4, 2026,** and none of the groups are fully formed. All the participants are appealing from Revised NPRs ("RNPRs"). The "Notice of Reopening" accompanying the RNPRs is the Administrator's Remand Order, as well as Change Request 13294 (Feb. 21, 2024), which was issued to Medicare Contractors "to provide guidance for the treatment of Medicare Part C days in the calculation of a provider's Medicare Disproportionate Share Hospital adjustment."[1] The RNPRs all show a $0 change in Medicare reimbursement and specifically note they were issued as a result of Change Request 13294. The relevant audit adjustments for all group participants are either silent to any substantive adjustment or specifically reference that no updated figures were used to implement Change Request 13294.

None of the issue statements contain any substantive discussion of the RNPRs, audit adjustments, or explain how the Board has jurisdiction over the standardized amount base rate issue from the RNPRs. The appeals concern whether certain base payment rates for IPPS hospitals in 1984 were based on data that erroneously mischaracterized "transfers" of patients as

[1] CMS Transmittal 12513, Change Request 13294 at 1 (Feb. 21, 2024).

"discharges." The errors in these base payment rates have allegedly been carried forward every year, resulting in understated IPPS and DSH payments for the years under appeal.[2]

Relevant Law:

A. RNPR Appeals

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2023), which provides, in relevant part:

> (a) General. (1) A Secretary determination, a contractor determination, or a decision by a reviewing entity (as described in § 405.1801(a)) may be reopened, with respect to specific findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the contractor (with respect to contractor determinations), or by the reviewing entity that made the decision. . . .

Additionally, 42 C.F.R. § 405.1889 (2023)[3] explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) ***Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.***
>
> (2) ***Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.***[4]

As outlined above, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[5]

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[2] *E.g.*, Case No. 26-1961G, Issue Statement (Mar. 4, 2026).
[3] *See also Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).
[4] (Bold and italics emphasis added.)
[5] 42 C.F.R. § 405.1889(b)(1).

B. Retroactive Part C Rule, Resulting RNPRs, and Associated Appeal Rights

i. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[6] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[7]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[8] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[9]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[10] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[11] The DPP is defined as the sum of two fractions expressed as percentages.[12] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), defines the Medicare/SSI fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[13]

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[6] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[7] *Id.*
[8] *See* 42 U.S.C. § 1395ww(d)(5).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[12] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[13] (Emphasis added.)

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[14]

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[15]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[16]

ii. Establishment of Medicare Part C and Treatment of Part C Days in the DSH Calculation

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations ("HMOs") and competitive medical plans ("CMPs") is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to an eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A and enrolled under part B . . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days.

In the September 4, 1990 Federal Register, the Secretary[17] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR)

[14] 42 C.F.R. § 412.106(b)(2)-(3).
[15] (Emphasis added.)
[16] 42 C.F.R. § 412.106(b)(4).
[17] of Health and Human Services.

> file that allows us to isolate those HMO days that are associated with Medicare patients. Therefore, since that time we have been including HMO days in SSI/Medicare percentage [of the DSH adjustment].[18]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[19]

With the creation of Medicare Part C in 1997,[20] Medicare beneficiaries who are entitled to Medicare Part A benefits may elect to receive managed care coverage under Medicare Part C, and following that election, the beneficiary's benefits are no longer administered under Medicare Part A.[21] As part of the federal fiscal year ("FFY") 2004 IPPS proposed rule, the Secretary noted she had received "questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation." In response to those questions, the Secretary proposed "to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage" but rather "[t]hese patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[22] The Secretary did not finalize that policy in the FFY 2004 IPPS final rule because the Secretary had not yet completed review of the large number of comments received.[23]

In the FFY 2005 IPPS proposed rule, the Secretary referenced the Part C proposal in the FFY 2004 IPPS proposed rule and stated her intention to address the comments received on that proposal in the FY 2005 IPPS final rule.[24] In the FFY 2005 IPPS final rule, the Secretary purportedly changed her proposal/position by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[25] In response to a comment regarding this change, the Secretary explained that:

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[18] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[19] *Id.*
[20] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015*, codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[21] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[22] *Id.*
[23] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[24] 69 Fed. Reg. 28196, 28286 (May 18, 2004).
[25] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[26]

This statement would require inclusion of Medicare Part C inpatient days in the Medicare fraction of the DSH calculation.

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, it was not codified into the Code of Federal Regulations. The Secretary did not codify the policy change until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[27] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[28] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[29]

There has been substantial litigation over whether enrollees in Part C plans are "entitled to benefits" under Medicare Part A when determining their placement in either the DSH Medicare or Medicaid fraction.

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[26] *Id.* (emphasis added).
[27] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[28] *Id*. at 47411.
[29] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[30]

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[31] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[32] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[33] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for FFYs 2014 and beyond.[34] However, at that point, no new rule had been adopted for FFYs 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the Part C policy adopted in the FFY 2005 IPPS final rule. In 2014 the Secretary published Medicare fractions for FFY 2012 which included Part C days.[35] A number of hospitals appealed this action.[36] In *Azar v. Allina Health Services* ("*Allina II*"),[37] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[38] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[39] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[40]

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[30] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[31] 746 F. 3d 1102 (D.C. Cir. 2014).
[32] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[33] *Id.* at 2011.
[34] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[35] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[36] The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo**(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board, **pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[37] 139 S.Ct. 1804 (2019).
[38] *Id.* at 1817.
[39] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[40] 139 S.Ct. at 1814.

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[41] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[42]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[43] The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[44]

Finally, the following excerpts from the June 9, 2023 Final Rule discussing a hospital's right to challenge the Part C days policy adopted therein make clear that the Secretary did not consider the final rule or subsequent publication of SSI ratios to be an appealable "final determination":

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[41] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[42] CMS Ruling 1739-R at 1-2.
[43] 88 Fed. Reg. 37772 (June 9, 2023).
[44] 88 Fed. Reg. at 37788 (emphasis in original).

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports***. *In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[45]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[46]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised* ***NPRs*** *will provide hospitals with a* ***vehicle to appeal*** *the new final action* even if the Medicare fraction or DSH payment does not change numerically."[47]

4. "*When the Secretary's treatment of Part C days in this final action is reflected* ***in NPRs and revised NPRs****, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation* ***by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[48]

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[45] 88 Fed. Reg. at 37774-75 (emphasis added).
[46] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[47] *Id.* at 37788 (emphasis added).
[48] *Id.* (emphasis added).

The above discussion in the preamble to the June 9, 2023 Final Rule makes clear that hospitals covered by that Final Rule would have appeal rights maturing with the yet-to-be-issued NPRs (original or revised) that would apply the finalized policy.

The Board also notes that, on September 30, 2025, the District Court for the District of Columbia issued a decision holding Part C enrollees are "entitled to [Part A] benefits" within the context of 42 U.S.C.§ 1395ww(d)(5)(F)(vi), even when they elect to receive Part C benefits.[49] It ruled, however, that the June 9, 2023 Final Rule is both impermissible retroactive[50] arbitrary and capricious.[51] The court ordered the parties to submit briefs on the appropriate remedy for the unlawful regulation,[52] and on August 28, 2026, the court vacated the June 9, 2023 Final Rule and remanded the case to the Secretary.[53] The time frame for the government to appeal this decision, however, has not yet elapsed.[54]

Decision of the Board:

A. Issues Appealed from RNPR

42 C.F.R. § 405.1889 governs the scope of appeals once a contractor determination is "reopened as provided in § 405.1885[.]" In this circumstance, Providers have *limited* appeal rights and are only able to appeal issues or matters that were "specifically revised" in the RNPRs.

The appeal rights detailed in the June 9, 2023 Final Rule specifically limit a provider's appeal rights to specific matters related to the actual RNPR (*i.e.*, the Part C Days policy). First, the Secretary made clear that the Part C Days rule could be appealed following the issuance of a new NPR or RNPR "***even if the Medicare fraction or DSH payment does not change numerically.***"[55] Thus, the new rule could be appealed even if the treatment of Part C Days was not "specifically revised."

The appeal rights, however, are strictly limited to the policy related to the treatment of Part C days. Following the issuance of a RNPR, the Secretary stated that Providers "***will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions contained in the NPRs or revised NPRs***[,]" "**will be able to challenge the agency's interpretation** [of the treatment of Part C days in this final action] by appealing those NPRs and revised NPRs[,]" and further stated that they "**can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[56]

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[49] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).
[50] *Id.* at *12-19.
[51] *Id.* at *19-22.
[52] *Id.* at *23.
[53] *Montefiore Med. Ctr. v. Kennedy*, 2026 WL 2547056, *14 (D.D.C. 2026).
[54] Fed. R. App. P. 4(a)(1)(B).
[55] 88 Fed. Reg. 37788 (emphasis added).
[56] *Id.* at 37787-88 (emphasis added).

The issue in these group appeals concerns whether certain base payment rates for IPPS hospitals in 1984 were based on data that erroneously mischaracterized "transfers" of patients as "discharges." The appeal of this issue was taken from RNPRs that were issued specifically to reflect and implement the treatment of Part C days as set forth in the June 23, 2023 Final Rule. The RNPRs make no changes at all to the Providers' payments or cost reports related to this specific issue. The Providers make no effort to demonstrate how these RNPRs or audit adjustments relates to this issue. The Providers make no mention of 42 C.F.R. 405.1889(b)(1), which addresses what may be appealed from an RNPR such as those in these cases. The only appeal rights stem from the 2023 Final Rule, which are specifically tied to the implementation of the new Part C Rule. The Board also notes that none of the Providers in these groups appear to have appealed the SSI Codes issue when appealing from their original NPRs, and only seek to pursue this issue from RNPRs that did not make any specific adjustments related to the issue.

Additionally, the Board notes that 42 C.F.R. § 405.1835 addresses the right to a board hearing for individual provider appeals, and in particular, § 405.1835(b) requires the hearing request to demonstrate that the provider satisfies the requirements for a hearing (*i.e.* establish Board jurisdiction) for each item appealed:

> [t]he provider's request for a Board hearing under paragraph (a) of this section . . . ***must*** include the elements described in paragraphs (b)(1) through (4) of this section. . . .
>
> * * *
>
> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific identification of the final contractor or Secretary determination under appeal.[57]

Accordingly, the Board notes that 42 C.F.R. § 405.1835(a)(1) states:

> [t]he provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. ***Exception: If a final contractor determination is reopened under § 405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination*** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).[58]

The right to establish a group is subject to parallel requirements at §§ 405.1837(c) and 405.1837(a)(1) respectively.[59] Further, Board Rule 4.1 (2023) states that "[t]he Board may

[57] 42 C.F.R. § 405.1835(b) (bold and italics emphasis added).
[58] (Bold and italics emphasis added.)
[59] In particular, 42 C.F.R. § 405.1837(c) states, in pertinent part: "The request for a Board hearing as a group appeal must be submitted in writing to the Board, and the request must include all of the following: (1) A demonstration

review jurisdiction on its own motion at any time." Similarly, 42 C.F.R. § 405.1837(e)(2) specifies that "[t]he Board may make jurisdictional findings . . . at any time."[60] In the instant cases the Board has done so, and has determined that the Providers have not met their burden to prove that the Board has jurisdiction, in accordance with the regulations at 42 C.F.R. §§ 405.1835(b)(1), 405,1837(c)(1), and 405.1889(b)(1), in these group appeals.

Conclusion:

The issue in these cases taken from the Providers' RNPRs concerns concern whether certain base payment rates for IPPS hospitals in 1984 were based on data that erroneously mischaracterized "transfers" of patients as "discharges" and the resulting impact on present day IPPS rates. The appeal of this issue was taken from RNPRs that were issued specifically to reflect and implement the treatment of Part C days as set forth in the June 9, 2023 Final Rule. The RNPRs made no changes at all to the Providers' payments or cost report related to the issue under appeal in these cases. The Providers make no effort to demonstrate how these RNPRs or audit adjustments relate to this issue to establish the Board's jurisdiction over these appeals notwithstanding their obligation to do so under 42 C.F.R. §§ 405.1835(b) and 405.1837(c).

The Board has reviewed the record in these cases and finds that (1) the RNPRs did not make "specific revisions" related to whether certain base payment rates for IPPS hospitals in 1984 were based on data that erroneously mischaracterized "transfers" of patients as "discharges," thus impacting present day IPPS rates and, as a result, pursuant to 42 C.F.R. § 405.1889(b)(1), that issue is beyond the scope of any appeal from the RNPRs, and (2) the only appeal rights afforded from the RNPRs as set forth in the June 9, 2023 Final Rule are to challenge the treatment of Part C Days in the RNPRs. Based on the foregoing, the Board is hereby ***dismissing*** Case Nos. 26-1961G, 26-1965G, and 26-1969G.[61]

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section."

[60] The only specified limitation is that the Board may not dismiss a group for failure to meet the amount in controversy requirement until after the group is fully formed.

[61] The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. §405.1889(b). *See, e.g., HCA Health Servs. of Okla. v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994); *McLaren Flint v. Azar*, 464 F. Supp. 3d 1 (D.D.C. 2020); *St. Mary's of Mich. v. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *Franciscan St. Margaret Health v. Azar*, 407 F. Supp. 3d 28 (D.D.C. 2019); *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *Illinois-Masonic Med. Ctr. v. Sebelius*, 859 F. Supp. 2d 137 (D.D.C. 2012).

Board Members:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq. (abstaining)[62]
Shakeba DuBose, Esq.
Clayton J. Nix, Esq.

For the Board:

9/10/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: KEVIN D. SMITH -A

cc: Wilson Leong, Esq. Federal Specialized Services
Cecilia Lukito, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)

[62] Board Member Musgrave declines to render an opinion on this matter. It is her contention that the Medicare Contractor has a responsibility to make its own legal and factual argument supporting a jurisdictional challenge (Board Rule 44.1) and that the Providers should be given the opportunity to file responses (Board Rule 44.3). She acknowledges that the Board may review jurisdiction on its own motion at any time (Board Rule 4.1). However, rather than forestall the Medicare Contractor's challenge with the Board's "Own Motion" determination, she would prefer that the Board instead allow the parties to present their own positions.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: **Notice of Dismissals**
Case Number: 26-0057GC - UNC Health CY 2007 Medicare DSH – Additional SSI Codes CIRP Group
Case Number: 26-1943G - Hooper Lundy & Bookman CY 2011 Medicare DSH – Additional SSI Codes Group
Case Number: 26-1962G - Hooper Lundy & Bookman CY 2006 Medicare DSH – Additional SSI Codes Group
Case Number: 26-1966G - Hooper Lundy & Bookman CY 2007 Medicare DSH – Additional SSI Codes Group
Case Number: 26-1970G - Hooper Lundy & Bookman CY 2008 Medicare DSH – Additional SSI Codes Group
Case Number: 26-2419G - Emory Healthcare CY 2013 Medicare DSH - Additional SSI Codes CIRP Group

Dear Ms. Carroll and Mr. Collins:

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the record in the above-referenced appeals. The decision of the Board to ***dismiss*** the six (6) group appeals is set forth below.

Procedural history:

These six (6) group appeals were filed between **October, 2025** and **April, 2026** and none of the groups are fully formed. All the participants are appealing from Revised NPRs ("RNPRs"). The "Notice of Reopening" accompanying the RNPRs was the Federal Register published June 9, 2023, as well as Change Request 13294 (Feb. 21, 2024), which was issued to Medicare Contractors "to provide guidance for the treatment of Medicare Part C days in the calculation of a provider's Medicare Disproportionate Share Hospital adjustment."[1] The RNPRs for all but one participant showed a $0 change in Medicare reimbursement and specifically note they were issued as a result of Change Request 13294. For Emory University Hospital Midtown (Prov. No. 11-0078) in Case 26-2419GC, the RNPR noted $372,592 was due to the Provider, but also specifically stated it was being issued pursuant to the PRRB remand of 19-2477GC, which was a Part C Days case. The relevant audit adjustments for all group participants are either silent to

[1] CMS Transmittal 12513, Change Request 13294 at 1 (Feb. 21, 2024).

any substantive adjustment or specifically reference that no updated figures were used to implement Change Request 13294.

None of the issue statements contain any substantive discussion of the RNPRs, audit adjustments, or explain how the Board has jurisdiction over the SSI Codes issue from the RNPRs. They explain that "[t]he purpose of this appeal issue is to require CMS to use additional SSI codes when determining which Medicare Part A beneficiaries are also 'entitled to' SSI for purposes of calculating the Hospitals' . . . Medicare/SSI fractions."[2]

Relevant Law:

A. RNPR Appeals

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2023), which provides, in relevant part:

> (a) General. (1) A Secretary determination, a contractor determination, or a decision by a reviewing entity (as described in § 405.1801(a)) may be reopened, with respect to specific findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the contractor (with respect to contractor determinations), or by the reviewing entity that made the decision. . . .

Additionally, 42 C.F.R. § 405.1889 (2023)[3] explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) ***Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.***
>
> (2) ***Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.***[4]

[2] *E.g.*, Case No. 26-1943GC, Issue Statement (Mar. 2, 2026).
[3] *See also Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).
[4] (Bold and italics emphasis added.)

As outlined above, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[5]

B. Retroactive Part C Rule, Resulting RNPRs, and Associated Appeal Rights

i. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[6] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[7]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[8] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[9]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[10] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[11] The DPP is defined as the sum of two fractions expressed as percentages.[12] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), defines the Medicare/SSI fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such

[5] 42 C.F.R. § 405.1889(b)(1).
[6] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[7] *Id.*
[8] *See* 42 U.S.C. § 1395ww(d)(5).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[12] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).

> days) were ***entitled to benefits under part A*** of this subchapter . . . .[13]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[14]

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[15]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[16]

ii. Establishment of Medicare Part C and Treatment of Part C Days in the DSH Calculation

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations ("HMOs") and competitive medical plans ("CMPs") is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to an eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A and enrolled under part B . . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days.

In the September 4, 1990 Federal Register, the Secretary[17] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate

[13] (Emphasis added.)
[14] 42 C.F.R. § 412.106(b)(2)-(3).
[15] (Emphasis added.)
[16] 42 C.F.R. § 412.106(b)(4).
[17] of Health and Human Services.

> the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that are associated with Medicare patients. Therefore, since that time we have been including HMO days in SSI/Medicare percentage [of the DSH adjustment].[18]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[19]

With the creation of Medicare Part C in 1997,[20] Medicare beneficiaries who are entitled to Medicare Part A benefits may elect to receive managed care coverage under Medicare Part C, and following that election, the beneficiary's benefits are no longer administered under Medicare Part A.[21] As part of the federal fiscal year ("FFY") 2004 IPPS proposed rule, the Secretary noted she had received "questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation." In response to those questions, the Secretary proposed "to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage" but rather "[t]hese patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[22] The Secretary did not finalize that policy in the FFY 2004 IPPS final rule because the Secretary had not yet completed review of the large number of comments received.[23]

In the FFY 2005 IPPS proposed rule, the Secretary referenced the Part C proposal in the FFY 2004 IPPS proposed rule and stated her intention to address the comments received on that proposal in the FY 2005 IPPS final rule.[24] In the FFY 2005 IPPS final rule, the Secretary purportedly changed her proposal/position by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the

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[18] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[19] *Id.*
[20] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[21] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[22] *Id.*
[23] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[24] 69 Fed. Reg. 28196, 28286 (May 18, 2004).

Medicare fraction of the DSH calculation."[25] In response to a comment regarding this change, the Secretary explained that:

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[26]

This statement would require inclusion of Medicare Part C inpatient days in the Medicare fraction of the DSH calculation.

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, it was not codified into the Code of Federal Regulations. The Secretary did not codify the policy change until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[27] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[28] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[29]

There has been substantial litigation over whether enrollees in Part C plans are "entitled to benefits" under Medicare Part A when determining their placement in either the DSH Medicare or Medicaid fraction.

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[25] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).
[26] *Id.* (emphasis added).
[27] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[28] *Id*. at 47411.
[29] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[30]

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[31] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[32] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[33] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for FFYs 2014 and beyond.[34] However, at that point, no new rule had been adopted for FFYs 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the Part C policy adopted in the FFY 2005 IPPS final rule. In 2014 the Secretary published Medicare fractions for FFY 2012 which included Part C days.[35] A number of hospitals appealed this action.[36] In *Azar v. Allina Health Services* ("*Allina II*"),[37] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[38] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[39] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[40]

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[30] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[31] 746 F. 3d 1102 (D.C. Cir. 2014).
[32] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[33] *Id.* at 2011.
[34] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[35] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[36] The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo**(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board, **pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[37] 139 S.Ct. 1804 (2019).
[38] *Id.* at 1817.
[39] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[40] 139 S.Ct. at 1814.

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[41] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[42]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[43] The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[44]

Finally, the following excerpts from the June 9, 2023 Final Rule discussing a hospital's right to challenge the Part C days policy adopted therein make clear that the Secretary did not consider the final rule or subsequent publication of SSI ratios to be an appealable "final determination":

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[41] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[42] CMS Ruling 1739-R at 1-2.
[43] 88 Fed. Reg. 37772 (June 9, 2023).
[44] 88 Fed. Reg. at 37788 (emphasis in original).

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports***. *In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[45]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[46]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised* ***NPRs*** *will provide hospitals with a* ***vehicle to appeal*** *the new final action* even if the Medicare fraction or DSH payment does not change numerically."[47]

4. "*When the Secretary's treatment of Part C days in this final action is reflected* ***in NPRs and revised NPRs****, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation* ***by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[48]

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[45] 88 Fed. Reg. at 37774-75 (emphasis added).
[46] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[47] *Id.* at 37788 (emphasis added).
[48] *Id.* (emphasis added).

The above discussion in the preamble to the June 9, 2023 Final Rule makes clear that hospitals covered by that Final Rule would have appeal rights maturing with the yet-to-be-issued NPRs (original or revised) that would apply the finalized policy.

The Board also notes that, on September 30, 2025, the District Court for the District of Columbia issued a decision holding Part C enrollees are "entitled to [Part A] benefits" within the context of 42 U.S.C.§ 1395ww(d)(5)(F)(vi), even when they elect to receive Part C benefits.[49] It ruled, however, that the June 9, 2023 Final Rule is both impermissible retroactive[50] arbitrary and capricious.[51] The court ordered the parties to submit briefs on the appropriate remedy for the unlawful regulation,[52] and on August 28, 2026, the court vacated the June 9, 2023 Final Rule and remanded the case to the Secretary.[53] The time frame for the government to appeal this decision, however, has not yet elapsed.[54]

Decision of the Board:

A. Issues Appealed from RNPR

42 C.F.R. § 405.1889 governs the scope of appeals once a contractor determination is "reopened as provided in § 405.1885[.]" In this circumstance, Providers have *limited* appeal rights and are only able to appeal issues or matters that were "specifically revised" in the RNPRs.

The appeal rights detailed in the June 9, 2023 Final Rule specifically limit a provider's appeal rights to specific matters related to the actual RNPR (*i.e.*, the Part C Days policy). First, the Secretary made clear that the Part C Days rule could be appealed following the issuance of a new NPR or RNPR "***even if the Medicare fraction or DSH payment does not change numerically.***"[55] Thus, the new rule could be appealed even if the treatment of Part C Days was not "specifically revised."

The appeal rights, however, are strictly limited to the policy related to the treatment of Part C days. Following the issuance of a RNPR, the Secretary stated that Providers "***will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions contained in the NPRs or revised NPRs***[,]" "**will be able to challenge the agency's interpretation** [of the treatment of Part C days in this final action] by appealing those NPRs and revised NPRs[,]" and further stated that they "**can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[56]

[49] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).
[50] *Id.* at *12-19.
[51] *Id.* at *19-22.
[52] *Id.* at *23.
[53] *Montefiore Med. Ctr. v. Kennedy*, 2026 WL 2547056, *14 (D.D.C. 2026).
[54] Fed. R. App. P. 4(a)(1)(B).
[55] 88 Fed. Reg. 37788 (emphasis added).
[56] *Id.* at 37787-88 (emphasis added).

The issue in these group appeals is related to expansion of SSI Data matching codes beyond the three used by CMS. The appeal of this issue was taken from RNPRs that were issued specifically to reflect and implement the treatment of Part C days as set forth in the June 23, 2023 Final Rule. The RNPRs make no changes at all to the Providers' payments or cost reports related to this specific issue. The Providers make no effort to demonstrate how these RNPRs or audit adjustments relate to this issue. The Providers make no mention of 42 C.F.R. 405.1889(b)(1), which addresses what may be appealed from an RNPR such as those in these cases. The only appeal rights stem from the 2023 Final Rule, which are specifically tied to the implementation of the new Part C Rule. The Board also notes that none of the Providers in these groups appear to have appealed the SSI Codes issue when appealing from their original NPRs, and only seek to pursue this issue from RNPRs that did not make any specific adjustments related to the issue.

Additionally, the Board notes that 42 C.F.R. § 405.1835 addresses the right to a board hearing for individual provider appeals, and in particular, § 405.1835(b) requires the hearing request to demonstrate that the provider satisfies the requirements for a hearing (*i.e.* establish Board jurisdiction) for each item appealed:

> [t]he provider's request for a Board hearing under paragraph (a) of this section . . . ***must*** include the elements described in paragraphs (b)(1) through (4) of this section. . . .
>
> * * *
>
> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific identification of the final contractor or Secretary determination under appeal.[57]

Accordingly, the Board notes that 42 C.F.R. § 405.1835(a)(1) states:

> [t]he provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. ***Exception: If a final contractor determination is reopened under § 405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination*** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).[58]

The right to establish a group is subject to parallel requirements at §§ 405.1837(c) and 405.1837(a)(1) respectively.[59] Further, Board Rule 4.1 (2023) states that "[t]he Board may

[57] 42 C.F.R. § 405.1835(b) (bold and italics emphasis added).
[58] (Bold and italics emphasis added.)
[59] In particular, 42 C.F.R. § 405.1837(c) states, in pertinent part: "The request for a Board hearing as a group appeal must be submitted in writing to the Board, and the request must include all of the following: (1) A demonstration

review jurisdiction on its own motion at any time." Similarly, 42 C.F.R. § 405.1837(e)(2) specifies that "[t]he Board may make jurisdictional findings . . . at any time."[60] In the instant cases the Board has done so, and has determined that the Providers have not met their burden to prove that the Board has jurisdiction, in accordance with the regulations at 42 C.F.R. §§ 405.1835(b)(1), 405,1837(c)(1), and 405.1889(b)(1), in these group appeals.

Conclusion:

The issue in these cases taken from the Providers' RNPR is related to expansion of SSI Data matching codes beyond the three used by CMS. The appeal of this issue was taken from RNPRs that were issued specifically to reflect and implement the treatment of Part C days as set forth in the June 9, 2023 Final Rule. The RNPRs made no changes at all to the Providers' payments or cost report related to the issue under appeal in these cases. The Providers make no effort to demonstrate how these RNPRs or audit adjustments relate to this issue to establish Board jurisdiction over these appeals notwithstanding their obligation to do so under 42 C.F.R. §§ 405.1835(b) and 405.1837(c).

The Board has reviewed the record in these cases and finds that (1) the RNPRs did not make "specific revisions" related to expansion of SSI Data matching codes beyond the three used by CMS and as a result, pursuant to 42 C.F.R. § 405.1889(b)(1), that issue is beyond the scope of any appeal from the RNPRs, and (2) the only appeal rights afforded from the RNPRs as set forth in the June 9, 2023 Final Rule are to challenge the treatment of Part C Days in the RNPRs. Based on the foregoing, the Board is hereby ***dismissing*** Cases 26-0057GC, 26-1943G, 26-1962G, 26-1966G, 26-1970G, and 26-2419GC.[61]

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section."

[60] The only specified limitation is that the Board may not dismiss a group for failure to meet the amount in controversy requirement until after the group is fully formed.

[61] The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. §405.1889(b). *See, e.g., HCA Health Servs. of Okla. v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994); *McLaren Flint v. Azar*, 464 F. Supp. 3d 1 (D.D.C. 2020); *St. Mary's of Mich. v. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *Franciscan St. Margaret Health v. Azar*, 407 F. Supp. 3d 28 (D.D.C. 2019); *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *Illinois-Masonic Med. Ctr. v. Sebelius*, 859 F. Supp. 2d 137 (D.D.C. 2012).

Board Members:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq. (abstaining)[62]
Shakeba DuBose, Esq.
Clayton J. Nix, Esq.

For the Board:

9/10/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: KEVIN D. SMITH -A

cc: Wilson Leong, Esq. Federal Specialized Services
Dana Johnson, Palmetto GBA c/o Wellpoint Federal Solutions, Inc. (J-M)
Cecilia Lukito, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-L)
Cecile Huggins, Palmetto GBA (J-J)

[62] Board Member Musgrave declines to render an opinion on this matter. It is her contention that the Medicare Contractor has a responsibility to make its own legal and factual argument supporting a jurisdictional challenge (Board Rule 44.1) and that the Providers should be given the opportunity to file responses (Board Rule 44.3). She acknowledges that the Board may review jurisdiction on its own motion at any time (Board Rule 4.1). However, rather than forestall the Medicare Contractor's challenge with the Board's "Own Motion" determination, she would prefer that the Board instead allow the parties to present their own positions.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

James Ravindran, President
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: **Determination re: Request for Reinstatement**
Case Number: 26-2931 - Cambridge Health Alliance (Provider Number 22-0011)
FYE: 06/30/2022

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the subject appeal in response to the request for reinstatement filed by Quality Reimbursement Services, Inc. ("QRS") on August 31, 2026. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

On **April 26, 2026**, QRS filed an appeal for Cambridge Health Alliance ("Cambridge"/Prov. No. 22-0011) for its fiscal year ("FY") *6/30/2021* under Case No. 26-2366.

On **August 10, 2026**, QRS filed an appeal for Cambridge for its subsequent FY *06/30/2022* under Case No. 26-2931. The FY 2022 appeal was allegedly filed from a Notice of Program Reimbursement ("NPR") dated February 11, 2026. The determination support uploaded by QRS, however, was a copy of a December 1, 2025 NPR for the Provider's FYE *6/30/2021*. The other issue support provided also referenced FY 2021 *(*i.e., calculation support, audit adjustment pages, protest support and issue statement.)[1]

On **August 31, 2026**, the Board dismissed Case No. 26-2931, finding that the Provider failed to meet the minimum filing requirements in 42 C.F.R. §§ 405.1835 - 405.1840 and the Board Rules when it failed to file a copy of the **correct** final determination under appeal.

On **August 31, 2026**, QRS requested reinstatement of the appeal. QRS acknowledged that the documentation initially submitted with the appeal request consisted of incorrect jurisdictional documents but explained that it inadvertently uploaded the documents from its FY 2021 appeal for the same provider that had been filed earlier, instead of the FY 2022 support.[2] QRS justified

[1] The issue statement concluded ". . . CMS's FYs 2020 and 2021 rural floor policy is invalid and cannot be enforced."
[2] The FY 2021 appeal had been filed more than 3 months earlier.

its position, explaining that the appeal's cited information was accurate and drawn from the actual 2022 documents, and that only the supporting documents had been mistakenly switched. In support of its request for reinstatement, QRS provided the correct documentation for FY 2022.[3]

Board Determination:

Pursuant to 42 U.S.C. §1395oo(a) and 42 C.F.R. §§405.1835-405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the contractor's final determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the requires for hearing is filed within 180 days of the date of receipt of the final determination.

QRS has filed a motion requesting that the Board reinstate Cambridge's appeal under Case No. 26-2931. Board Rule 47.1 governs motions for reinstatement of an issue or case:

> **47.1 Motion for Reinstatement**
>
> A provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the provider's withdrawal of the issue(s) (see 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (see Rule 44 governing motions). **The Board will not reinstate an issue(s)/case if the provider was at fault. . . .**
>
> . . . .
>
> **47.3 Dismissals for Failure to Comply with Board Procedures**
>
> **Upon written motion demonstrating good cause**, the Board may reinstate a case dismissed for failure to comply with Board procedures. Generally, **administrative oversight**, settlement negotiations or a change in representative **will not be considered good cause to reinstate**. . . .[4]

Board Rule 47.1 makes clear that the Board will not reinstate a case or issue **if the provider was at fault.** Additionally, the Board refers the Representative to Board Rule 47.3, which is specific to dismissals due to failure to comply with Board procedures, which details what the Board **does not consider to be good cause for reinstatement**, specifically, *administrative oversight*. In this case, the Board finds that the Representative was at fault for providing the incorrect support documents referencing a different FY than the one under appeal due to a self-admitted administrative error.

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[3] QRS provided the FY 2022 NPR, Audit Adjustment Pages, Protest Support, and Calculation Support.
[4] (Bold emphasis added, with the exception of the titles which had bold emphasis in original.)

The Board agrees that the Representative has cured the defect in this case by belatedly filing a copy of the correct final determination and other issue related support for FY 2022 with its motion for reinstatement. In addition, the Board has considered QRS' concession that it "inadvertently included" the documents for the prior year's appeal but that all information cited in the appeal was actually for the correct FY 2022.[5] Nevertheless, the Provider still had an obligation to submit a copy of the correct NPR under appeal when it filed. Because it did not, the Provider failed to comply with 42 C.F.R. § 405.1835(b)(3), which requires that an appeal include ". . . a copy of the final contractor or Secretary determination under appeal."

The Board also considered whether the Provider's August 31, 2026 Motion for Reinstatement, along with the corrective documentation, could qualify as a timely appeal request. However, because the FY 2022 NPR is dated February 11, 2026, the deadline for filing an appeal was Friday, August 15, 2026. As a result, the reinstatement request itself, which was filed two weeks beyond that deadline, cannot be treated as a timely filed appeal. Here, the Provider's delay in filing its original appeal request until the end of the 180-day filing period proved to be detrimental.

Finally, the Board finds the Representative's motion for reinstatement to be deficient. QRS did not include a statement, as required by Board Rule 44.2, confirming that it had contacted the Medicare Contractor prior to filing the motion to determine whether the Medicare Contractor concurred.[6]

* * *

The Board finds it properly exercised its authority under 42 C.F.R. § 405.1868(b) to dismiss the subject case and declines to exercise its discretion to reinstate Case No. 26-2931. The Board finds that the Representative was at fault and failed to establish good cause under Board Rules 47.1 and 47.3 as it admitted fault for not including a copy of the correct final determination under appeal. In addition, the Representative failed to confer with the Medicare Contractor prior to filing the motion as required by Board Rules 47.1 and 44. Accordingly, this case remains closed and off the Board's docket.

Board Members:
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba Dubose, Esq.
Clayton J. Nix, Esq.

FOR THE BOARD:

9/11/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: KEVIN D. SMITH -A

cc: Wilson C. Leong, Federal Specialized Services
Danelle Decker, Wellpoint Federal Solutions, Inc. (J-K)

[5] Motion and Request for Reinstatement at 1 (Aug. 31, 2026).
[6] Board Rules v 3.2 (Dec. 15, 2023) Rule 44.2: Duty to Confer.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Leslie Goldsmith, Esq.
Bass, Berry & Sims, PLC
1201 Pennsylvania Avenue NW, Suite 300
Washington, D.C. 20004

RE: ***Expedited Judicial Review Decision***

Case Number: 26-0297GC - Main Line Health CY 2022 Capital DSH CIRP Group

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the **August 28, 2026** consolidated Petition for Expedited Judicial Review[1] ("EJR") for the above-referenced common issue related party ("CIRP") group appeal. The decision with respect to EJR is set forth below.[2]

Issue under Dispute

In these group cases, the Providers are challenging:

> the validity of the regulation at 42 C.F.R. § 412.320(a)(1)(iii), which bars hospitals that are geographically urban and reclassify as rural under 42 C.F.R. § 412.103 from receiving a capital disproportionate share hospital ("DSH") add-on payment, known as the capital DSH adjustment. The Providers challenge the validity of 42 C.F.R. § 412.320(a)(1)(iii) on a number of grounds including that the regulation (a) is inconsistent with the controlling Medicare statute, (b) was adopted in violation of the Administrative Procedure Act, and (c) is arbitrary and capricious.[3]

Background:

Under the inpatient prospective payment system ("IPPS"), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for operating costs ("operating IPPS") as set forth at § 1395ww(d); and one for capital costs ("capital IPPS") as set forth at 42 U.S.C. § 1395ww(g). The primary objective of IPPS is to

[1] Providers' Petition for Expedited Judicial Review (Aug. 28, 2026) ("Request for EJR").
[2] The Request for EJR encompasses five (5) group cases. Pursuant to Board Rule 44.6 (2023), the Medicare Contractor and/or its representative made filings which indicated they would be submitting Substantive Claim Challenges in Case Nos. 25-5165G, 25-5418G, 25-5476G, and 26-1073GC, which will be addressed by the Board under separate cover.
[3] Request for EJR at 1.

create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.[4] This case focuses on the capital IPPS.

1. Geographic Reclassification

In 1989, Congress created the Medicare Geographic Classification Review Board ("MGCRB") which implemented a geographic reclassification system in which IPPS hospitals can be reclassified to a different wage index area[5] for purposes of receiving a higher payment rate if they meet certain criteria related to proximity and average hourly wage.[6] This includes an IPPS hospital reclassifying from a rural to an urban labor market, or vice versa.

2. Operating DSH Adjustment Under Operating IPPS

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under operating IPPS.[7] Under the operating IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[8]

The statute governing operating IPPS contains a number of provisions that adjust reimbursement based on hospital-specific factors.[9] One of the adjustments is the hospital-specific Disproportionate Share Hospital ("DSH") adjustment as set forth at 42 U.S.C. § 1395ww(d)(5)(F), which requires the Secretary to provide an adjustment (*i.e.*, an increase in the operating IPPS payment) to hospitals that "serve [] a significantly disproportionate number of low-income patients."[10]

A hospital may qualify for a DSH adjustment to its operating IPPS payments based on its disproportionate patient percentage ("DPP").[11] As a proxy for utilization by low-income

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[4] Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), *available at* https://oig.hhs.gov/oas/reports/region1/11700500.pdf (last visited Nov. 20, 2025) ("*Significant Vulnerabilities*").
[5] *See* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10).).
[6] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). *See also Significant Vulnerabilities* at 4-5.
[7] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[8] *Id.*
[9] *See* 42 U.S.C. § 1395ww(d)(5).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).

patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[12]

The DSH adjustment provided under operating IPPS is ***not*** at issue in this case. The DSH adjustment is relevant because certain standards are set forth in 42 U.S.C. § 1395ww(d)(5)(F) for the DSH adjustment that the Secretary adopted for purposes of capital IPPS.

3. Capital DSH Adjustment Under Capital IPPS

A hospital's *capital* costs are paid separately under capital IPPS (*i.e*., separate and apart from payment for a hospital's *operating* costs under the operating IPPS). Specifically, on December 22,1987, Congress enacted the Omnibus Budget Reconciliation Act of 1987 ("OBRA-87") and OBRA-87 § 4006(b) required the Secretary to establish the capital IPPS for cost reporting periods beginning in FY 1992.[13] OBRA-87 § 4006(b) was codified at 42 U.S.C. § 1395ww(g) which states, in pertinent part:

> **(g) Prospective payment for capital-related costs; return on equity capital for hospitals**
>
> (1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary *shall,* for hospital cost reporting periods beginning on or after October 1, 1991, *provide for payments for such costs* in accordance with a prospective payment system established by the Secretary. . . .
>
> (B) Such system— (i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;
>
> (ii) *may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located*;
>
> (iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and
>
> (iv) may provide for suitable adjustment to reflect hospital occupancy rate.

[12] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[13] Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).

> (C) In this paragraph, the term ‘‘capital-related costs’’ has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.[14]

Significantly, the statute governing capital IPPS does not specifically mandate or address the use of a capital DSH adjustment. Rather, it specifies generally that the Secretary "may provide for an adjustment to account variations in relative costs." As described below, the Secretary exercised his discretion to establish the c*apital* DSH adjustment at issue in this case which is limited in that it ***only*** applies to *urban* hospitals with 100 or more beds and that serve low income patients.[15]

1. Initial Implementation of Capital IPPS and the Capital DSH Adjustment

To the end, the Secretary published a final rule on August 30, 1991 to establish the capital IPPS.[16] In implementing the capital IPPS, the Secretary recognized that he had discretion on whether to apply many of the adjustments statutorily required under operating IPPS to capital IPPS:

> We are persuaded by the argument advanced by some commenters, including ProPAC, that in the long run the ***same*** adjustments should be applied to capital and operating payments and that the level of the adjustments should be determined by examining combined operating and capital costs. ProPAC recommended that the unified adjustments be calculated within two years. However, we believe that it would be most appropriate to implement these adjustments with respect to the capital prospective payment systems from the outset. *While the payment adjustments for the operating prospective payment system are determined by the Act (and therefore cannot be modified by the rulemaking process),* ***we have the latitude to develop adjustments based on combined costs for the capital prospective payment system***.
>
> We do not believe that it would be appropriate to use the current operating payment adjustments in the capital prospective payment system either permanently or on an interim basis until legislation is enacted changing the operating adjustments to the level appropriate for total costs. This is because the levels of the operating payment adjustments for serving a disproportionate share of low income patients (DSH) and for indirect medical education costs (IME)

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[14] (Underline and italics emphasis added.)
[15] 42 C.F.R. § 412.320(a)(1). *See also* MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics*, 2 (rev. Nov. 2021), *available at* https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited Sept. 11, 2026).
[16] 56 Fed. Reg. 43356 (Aug. 30, 1991).

> exceed the levels supported by empirical analysis. We believe the payment adjustments should be empirically supported and should reflect only the higher Medicare costs associated with teaching activity and treating low income patients.[17]

The Secretary did adopt a limited DSH adjustment to capital IPPS for urban hospitals with more than 100 beds. The proposal was described as follows:

> In the proposed rule, our regression results indicated that for urban hospitals with more than 100 beds, the disproportionate share percentage of low income patients has an effect on capital costs per case. We proposed that urban hospitals with 100 or more beds would receive an additional payment equal to ({1 +DSHP)$^{0\text{-}4176}$ - 1)), where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.
>
> Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.[18]

In adopting his proposal, the Secretary gave the following justification:

> *Comment*: Many commenters believe that the disproportionate share patient percentage of 30 percent needed to qualify for the special exceptions payment under the proposal is too restrictive. Most of these commenters supported the use of 20.2 percent as the patient threshold percentage since that is the patient percentage above which operating disproportionate share payments become more generous. Some believe that any hospital that received DSH payments under the operating system should be eligible for the special exception.
>
> *Response*: In the final rule, we are providing that urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or higher will be eligible to receive exceptions payments based on a higher minimum payment level

[17] *Id.* at 43369-70 (emphasis added).
[18] *Id* at 43377.

> than other hospitals. For FY 1992, the minimum payment level is 80 percent. Urban hospitals with 100 or more beds that receive disproportionate share payments under § 412.106(C)(2) would also be eligible for the higher minimum payment level. We are not extending the special protection to other hospitals that receive disproportionate share payments under the operating prospective payment system. In urban areas, we believe that our criteria properly focuses on those hospitals that serve a large disproportionate share population. Other urban hospitals receiving disproportionate share payments tend to serve fewer low income patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries**.[19]

In response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to rural hospitals with 500 or more beds:

> As part of our regression analysis for this final rule, we examined the relationship between total cost per case and disproportionate share patient percentages for rural hospitals with at least 500 beds, and found no statistically significant relationship. As a result, we are not implementing any disproportionate share adjustment to prospective payments for capital for these hospitals. Hospitals that qualify for additional operating disproportionate share payments under section 1886(d)(5)(F)(i)(II) of the Act will be deemed to have a disproportionate patient percentage equivalent to that which would generate their operating disproportionate share payment, using the formula for urban hospitals with at least 100 beds. For discharges occurring on or after October 1,1991, these hospitals qualify for an operating adjustment of 35 percent, which is equivalent to having a disproportionate share patient percentage of 65.4. Urban hospitals with more than 100 beds that qualify for additional operating disproportionate share payments under section 1866(d)(5)(F)(i)(II) of the Act will be deemed to qualify for additional capital disproportionate share payments as well at the level consistent with their deemed disproportionate share patient percentage. The disproportionate share adjustment factor for these hospitals is 14.16 percent. The additional capital disproportionate share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are,

[19] *Id.* at 43409-10 (bold and underline emphasis added).

> that is, as the result of the application by these hospitals for payments under § 412.106(b)(l){ii) of the regulations.[20]

Similarly, in response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to other classes of hospitals such as "[a]ll small urban hospitals, hospitals with high Medicare usage, rural hospitals, rural hospitals with at least 100 beds, rural referral centers, or those hospitals with high 'total government' usage":

> In developing the capital disproportionate share adjustment for this final rule, we examined the relationship between the disproportionate share patient percentage and total costs per case for each class of hospital that is currently receiving an operating payment adjustment. We believe that only those hospitals that merit the adjustment according to our regression analysis should receive additional capital payments for serving low income patients. The regression results did not indicate any significant relationship between total costs per case and disproportionate share patient percentage for any of the special groups mentioned above.[21]

In response to comments, the Secretary also looked at setting a threshold DSH percentage to qualify for a capital DSH adjustment but rejected that alternative approach based upon the following explanation:

> We examined closely the possibility of using a disproportionate share patient percentage threshold in our total cost regression analysis. We were unable to find any threshold level of disproportionate share percentage below which no payment adjustment was merited, or a threshold above which a higher adjustment was merited. As a result, we believe that it is most equitable to make a capital disproportionate share payment to all qualifying hospitals with a positive patient percentage, rather than penalize some hospitals that have a higher cost of treating low income patients but whose patient percentage is below the artificial level we would set.[22]

Further, in response to comments, the Secretary rejected not providing *any* capital DSH adjustment based on the explanation:

> We disagree with the commenter. The regression analyses show that serving low income patients (as defined in section 1886(d)(5)(F)(vi) of the Act) results in higher Medicare capital and total costs per case *for urban hospitals with at least 100 beds*. We

[20] *Id.*
[21] *Id.* at 43378.
[22] *Id.* at 43379.

> believe that it is appropriate for Medicare's payment to recognize these higher Medicare patient care costs.[23]

Finally, the Secretary addressed how MGCRB reclassifications, in certain circumstances, affect whether an IPPS hospital qualifies for the capital DSH adjustment:

> *Comment*: Many commenters sought clarification of the effect of reclassification by the Medicare Geographic Classification Review Board (MGCRB) on eligibility for capital disproportionate share payments.
>
> *Response*: Any hospital that is reclassified to an urban area by the MGCRB for purposes of its standardized amount is considered to be urban for all prospective payment purposes other than the wage index. As such, if any hospital reclassified by the MGCRB to an urban area for purposes of the standardized amount has at least 100 beds, it would be eligible for capital disproportionate share payments. We note that a rural hospital reclassified for purposes of the wage index only is still considered a rural hospital, and as such, will not be eligible for capital disproportionate share payments.[24]

The resulting regulations governing capital IPPS were codified at 42 C.F.R. Part 412, Subpart M (§§ 412.300 to 412.374). The regulation governing the capital DSH adjustment was codified at § 412.320 which, at initial implementation, stated:

> **§ 412.320 Disproportionate share adjustment factor.**
>
> (a) *Criteria for classification*. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area, has 100 or more beds as determined in accordance with § 412.105(b) and serves low-income patients, as determined under § 412.106(b), or if the hospital meets the criteria in § 412.106(c)(2).
>
> (b) *Payment adjustment factor*. (1) <u>If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments</u>, the disproportionate share payment adjustment factor equals [e raised to the power of (.2025 X the hospital's disproportionate patient percentage as determined under § 412.106(b)(5)), —1], where e is the natural antilog of 1.

[23] (Emphasis added.)
[24] 56 Fed. Reg. 43379.

> (2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.[25]

2. *Reclassification of Certain IPPS Urban Hospitals as Rural for Purposes of Operating IPPS Pursuant to BBRA § 401 and Impact on Capital IPPS Adjustments*

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ("BBRA") and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if an application is submitted to the MGCRB and certain criteria are met.[26] IPPS hospitals are reclassified per BBRA § 401 are often referred to as "§ 401 hospitals."

On August 1, 2000, the Secretary published the interim final rule to, in part, implement BBRA § 401 and stated in the preamble that a hospital reclassified as rural pursuant to § 401 is treated as rural for ***all*** purposes under operating IPPS, including the DSH adjustment for operating IPPS:

> *A hospital that is reclassified as rural* under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113, ***is treated as rural for all purposes*** *of payment under the Medicare inpatient hospital prospective payment system* (section 1886(d) of the Act), *including* standardized amount (§§ 412.60 et seq.), wage index (§ 412.63), and ***disproportionate share calculations*** (§ 412.106) as of the effective date of the reclassification.[27]

On August 1, 2000, the Secretary also published the FY 2001 IPPS Final Rule which included the following discussion on the effect of reclassification of a hospital from urban to rural pursuant to BBRA § 401:

> In the May 5, 2000 proposed rule, we indicated that we are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the benefits afforded to rural hospitals) and in turn seek reclassification through the MGCRB back to the urban area for purposes of their standardized amount and wage index and thus also receive the higher payments that might result from being treated as being located in an urban area. ***That is, we were concerned that some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes***. In light of the Conference Report language noted above discussing the House bill and what appears to be the potential for

[25] *Id*. at 43452-53.
[26] BBRA, Pub. L. 106-113, App. F, § 401, 113. Stat. 1501A-321, 1501A-369 (1999).
[27] 65 Fed. Reg. 47026, 47030 (Aug. 1, 2000) (emphasis added.)

inappropriately inconsistent treatment of the same hospital on the other hand, in the May 5 proposed rule, we solicited public comment on this issue, and indicated that we might impose a limitation on such MGCRB reclassifications in this final rule for FY 2001, if such action appears warranted. We also sought specific comments on how such a limitation, if any, should be imposed and provided several examples and alternatives.

****

Consistent with the statutory language, we are providing that a hospital reclassified as rural under section 1886(d)(8)(E) of the Act will be treated as being located in a rural area for purposes of section 1886(d) of the Act, and cannot subsequently be reclassified under the MGCRB process to an urban area (in order to be treated as being located in an urban area for certain purposes under section 1886(d) of the Act).

This policy is consistent not only with the statutory language but also with the policy considerations underlying the MGCRB process. The MGCRB process permits a hospital to be reclassified from one geographic area to another if it is significantly disadvantaged by its geographic location and would be paid more appropriately if it were reclassified to another area. We believe that it would be illogical to permit a hospital that applied to be reclassified from urban to rural under section 1886(d)(8)(E) of the Act because it was disadvantaged as an urban hospital to then utilize a process that was established to enable hospitals significantly disadvantaged by their rural or small urban location to reclassify to another urban location. *If an urban hospital applies under section 1886(d)(8)(E) of the Act in order to be treated as being located in a rural area, then it would be anomalous at best for the urban hospital to subsequently claim that it is significantly disadvantaged by the rural status for which it applied and should be reclassified to an urban area. Furthermore, permitting hospitals the option of seeking rural reclassification under section 1886(d)(8)(E) of the Act for certain payment advantages, coupled with the ability to pursue a subsequent MGCRB reclassification back to an urban area, could have implications beyond those originally envisioned under Public Law 106–113*. In particular, we are concerned about the potential interface between rural reclassifications under section 401 and section 407(b)(2) of Public Law 106– 113, which authorizes a 30-percent expansion in a rural hospital's resident full-time equivalent count for purposes of Medicare payment for the indirect costs of medical education (IME) under section 1886(d)(5)(B) of the Act. (Reclassification from urban to rural under section 1886(d)(8)(E) of the Act can affect IME payments to a hospital, which are made under section 1886(d)(5)(B) of the Act, but not payments for the direct costs of GME, which are made under section 1886(h) of the Act.)

> Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result. For example, some hospitals currently located in very large urban counties are in fact fairly small, isolated hospitals. Some of these hospitals will now be able to be designated a rural hospital and become eligible to be designated a critical access hospital.
>
> ****
>
> We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassification by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.
>
> ****
>
> *We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary*. ***Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify***. As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.[28]

Thus, both the August 1, 2000 interim final rule and the FY 2001 IPPS Final Rule confirmed that urban hospitals reclassified as rural pursuant to BBRA § 401 would be treated as rural for all purposes of operating IPPS, including DSH adjustments. The Secretary memorialized this policy in regulation at 42 C.F.R. § 412.103 (2000) which states in pertinent part:

> **§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural**.
>
> (a) *General criteria*. A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
>
> 1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and Services Administration which is available via the ORHP website at http:// www.nal.usda.gov/orph or from the U.S. Department of

[28] 65 Fed. Reg. 47054, 47088-89 (Aug. 1, 2000).

> Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9–05, Rockville, MD 20857.
>
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.
>
> (3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.[29]

Neither the August 1, 2000 interim final rule nor the FY 2001 IPPS Final Rule explicitly discussed the impact on capital DSH adjustments under capital IPPS. However, through operation of the cross-reference in 42 C.F.R. § 412.320(a) to § 412.63(a) in the phrase "the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area",[30] it would appear that hospitals reclassified from urban to rural were ***not*** eligible for capital DSH adjustments under capital IPPS. In this regard, the Board notes that, following the 2000 rulemaking process, § 412.63(a)-(b) (2001) read, in pertinent part:

> (a) *General rule*. (1) HCFA determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system, and determines a regional adjusted prospective payment rate for operating costs for such discharges in each region, for which payment may be made under Medicare Part A.
>
> (2) **Each such rate is determined for hospitals located in urban <u>or</u> rural areas** within the United States and within each such region respectively, **as described in paragraphs (b)** through (g) of this section.
>
> (b) *Geographic classifications*. (1) For purposes of this section, the definitions set forth in § 412.62(f) apply, **except that**, effective January 1, 2000, **a hospital reclassified as rural may mean** a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or **a reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103**.[31]

The specific reference in § 412.63(b) to urban to rural reclassifications made under § 412.103 makes clear that capital DSH adjustments would not apply to hospitals reclassified from urban to rural pursuant to BBRA § 401 which, as noted above, was implemented at § 412.103.

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[29] 65 Fed. Reg. 47026, 47048.
[30] 56 Fed Reg. at 43452.
[31] (Bold and underline emphasis added.)

3. Changes to Operating IPPS Required by MMA § 401 and Their Effect on Capital IPPS

On December 8, 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA") and MMA § 401 to equalize operating IPPS payments between urban and rural hospitals.[32] Specifically, § 401 specifies that, beginning with FY 2004, all IPPS hospitals are paid on the basis of the large urban standardized amount under operating IPPS.

The Office of Management and Budget publishes information on core-based statistical areas ("CBSAs") and the Secretary has used this information for purposes of defining labor market areas for use in the wage index for operating IPPS.[33] On June 6, 2003, OMB announced the new CBSAs, comprised of metropolitan statistical areas ("MSAs") and the new Micropolitan Areas based on Census 2000 data.[34]

On August 11, 2004, the Secretary published the FY 2005 IPPS Final Rule and this rule finalized revisions to the operating IPPS regulations to both implement MMA § 401 as well as adopt OMB's new CBSA designations.[35] With respect to implementing MMA § 401, the Secretary revised 42 C.F.R. § 412.63 to apply only to years through 2004 and added a new § 412.64 to implement MMA § 401 for federal rates for FYs 2005 forward. Specifically, § 412.64, reads in pertinent part:

> **§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.**
>
> (a) *General rule*. CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.
>
> (b) *Geographic classifications*. (1) For purposes of this section, the following definitions apply:
>
> (i) The term region means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.
>
> (ii) The term *urban area* means—

[32] Pub. L. 108–173.
[33] 69 Fed. Reg. 48916, 49026 (Aug. 11, 2004).
[34] *Id.*
[35] *Id.*

> (A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or
>
> (B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.S. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.
>
> (C) The term *rural area* means any area outside an urban area.
>
> (D) The phrase *hospital reclassified as rural* means a hospital located in a county that, in FY 2004, was part of an MSA, but was redesignated as rural after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.
>
> (2) For hospitals within an MSA that crosses census division boundaries, the MSA is deemed to belong to the census division in which most of the hospitals within the MSA are located.
>
> (3) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the Federal Register on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.
>
> (4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result of redesignation of an MSA by the Executive Office of Management and Budget.[36]

[36] *Id.* at 49242. *See also id.* at 49103 (discussing implementation of MMA § 401).

Significantly, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

The Secretary also amended 42 C.F.R. § 412.320(a). As previously noted, § 412.320(a) originally only referenced § 412.63: "A hospital is classified as a 'disproportionate share hospital' for the purposes of capital prospective payments if the hospital is located, *for purposes of receiving payment under § 412.63(a)*, in an urban area."[37] As a result of the FY 2005 IPPS Final Rule, § 412.320(a) was updated to reference § 412.64 as it relates to FYs 2005 forward:

> **§ 412.320 Disproportionate share adjustment factor.**
>
> (a) *Criteria for classification*. A hospital is classified as a ''disproportionate share hospital'' for the purposes of capital prospective payments if either of the following conditions is met:
>
> (1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).
>
> (i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).
>
> (ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64.[38]

Again, as previously noted, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

Finally, in the preamble to the FY 2005 IPPS Final Rule, the Secretary included the following discussion on the impact of the new CBSAs on geographic reclassifications:

> Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital-related costs rely on the existing geographic classifications set forth at § 412.63. Because we proposed to adopt OMB's new CBSA designations for FY 2005 and thereafter, under proposed new § 412.64, we proposed to revise § 412.316(b) and § 412.320(a)(1) to specify that, for discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.

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[37] (Emphasis added.)
[38] 42 C.F.R. § 412.320 (2004) (underline emphasis added). *See also* 69 Fed. Reg. at 49250.

> ****
>
> The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment adjustment) under the IPPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified and, therefore, will not be eligible to receive those additional payments under the IPPS for capital-related costs beginning in FY 2005. As we noted previously, we received no comments on that clarification.
>
> ****
>
> As previously discussed, we proposed and adopted as final our policy that, beginning in FY 2005 and thereafter, only those hospitals geographically located in a large urban area (as defined in revised § 412.63(c)(6)) will be eligible for the large urban add-on payment adjustment provided under § 412.312(b)(2)(ii) and § 412.316(b). *Similarly, beginning in FY 2005 and thereafter, to receive capital IPPS DSH payments under § 412.320, a hospital will need to be geographically located in an urban area (as defined in new § 412.64) and meet all other requirements of § 412.320.* Accordingly, we are adopting our proposed revisions as final without change.[39]

4. August 18, 2006 Revisions to the Capital DSH Adjustment

In the FY 2007 Proposed IPPS Rule, the Secretary[40] announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH

[39] 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004).
[40] of the Department of Health and Human Services.

adjustment. These proposed changes reflected the historic policy that hospitals reclassified as rural under § 412.103 also would be considered rural under the capital IPPS. Since the genesis of the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.[41]

The Secretary believed that these proposed changes and clarifications were necessary because the agency's capital IPPS regulations had been updated to incorporate the Office of Management and Budget's ("OBM's") new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005.[42]

In the FY 2007 IPPS Final Rule published on August 18, 2006, the Secretary finalized these technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment:

> These changes were proposed to reflect our historic policy that hospitals reclassified as rural under § 412.103 also are considered rural under the capital PPS. Since the genesis of the capital PPS in FY 1992, the same geographic classifications used under the operating PPS also have been used under the capital PPS.
>
> These changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, we revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).
>
> We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are

[41] 71 Fed. Reg. 23995, 24122 (Apr. 25, 2006).
[42] *Id.*

> reclassified from urban to rural under § 412.103 would be considered rural.[43]

In adopting these changes, the Secretary noted that it did not receive any public comments on the proposed change as published in the proposed rule published on May 17, 2006.[44]

As a result of the FY 2007 IPPS Final Rule, the regulation, subparagraph (iii) was added to 42 C.F.R. § 412.320(a)(1) so that revised § 412.320(a) read, in pertinent part:

> (a) *Criteria for classification*. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if either of the following conditions is met:
>
> (1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).
>
> (i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).
>
> (ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.
>
> **(iii) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.[45]**

5. *Litigation Challenging the Validity of 42 C.F.R. § 412.320(a)(1)(iii) as added by the FY 2007 IPPS Final Rule*

The validity of 42 C.F.R. § 412.320(a)(1)(iii) was addressed in *Toledo Hosp. v. Becerra* ("*Toledo*"),[46] wherein the hospital made the following contentions:

> Toledo Hospital contends that the Secretary's 2006 rulemaking is arbitrary and capricious and thus unreasonable for two principal reasons. First, it charges the Secretary with misrepresenting the

[43] 71 Fed. Reg. 47870, 48104 (Aug. 18, 2006).
[44] *Id.* at 48105.
[45] (Bold emphasis added.)
[46] 621 F.Supp.3d 13 (D.D.C. 2021).

> regulatory history in claiming that the 2006 Rule merely restored a previously implemented policy. Second, the hospital argues that the Secretary failed to "take into account" relative costs of capital for various hospital types and areas of location, as subsection (g) requires.[47]

In *Toledo*, U.S. District Court for the District of Columbia ("D.C. District Court") outlined the legislative history surrounding the creation of the MGCRB in 1989 which, as noted above, can redesignate IPPS hospitals to different labor market areas in order to receive a different wage reimbursement rate.[48] The Court also noted how Congress enacted legislation in 1999[49] allowing IPPS hospitals to reclassify from an urban labor market area to a rural one for various reasons. Thus, a geographically urban hospital can be classified as rural, but then redesignate itself back into an urban labor market area for the purposes of fixing its wage index.[50] The Court also noted the separate IPPS payment for a hospital's *capital* costs at 42 U.S.C. § 1395ww(g) (compared to the IPPS payment for *operating* costs), as well as the capital IPPS adjustments found at 42 C.F.R. § 412.320 for large urban hospitals (the capital DSH payment).[51] The Court explained that, following the 2006 rulemaking, a geographically urban hospital which reclassifies as rural under § 401 loses its eligibility for the capital DSH adjustment.[52]

The appellants in *Toledo* were geographically located in an urban labor market area, but applied to the Secretary (and were approved) to reclassify as rural under § 401. The appellants thereafter applied to the MGCRB to reclassify their wage index to an urban labor market area. The appellants' Medicare Contractor later denied their requests for capital DSH adjustments due to their § 401 rural reclassifications. Before the D.C. District Court, the hospitals argued that 42 C.F.R. § 412.320(a)(1)(iii) violated the plain language of the Medicare Act and that it was promulgated in in an arbitrary and capricious manner.[53]

The D.C. District Court rejected the argument that the capital DSH policy in 42 C.F.R. § 412.320(a)(1)(iii) violated the Medicare Act on its face, finding that the Secretary was not prohibited from treating § 401 reclassified hospitals as rural for operating PPS purposes while denying urban status for the purposes of the capital DSH adjustment.[54] The Court next examined, however, whether the Secretary's decision to do so was reasonable. The D.C. District Court made the following findings:

1. "if the Secretary had any policy concerning Section 401 reclassifications before 2006, he never announced such a policy, much less explained the basis for it."[55]

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[47] *Id.* at *25 (citations omitted).
[48] *Id.* at *18-19.
[49] 42 U.S.C. § 1395ww(d)(8)(E). *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, § 401, Pub. L. No. 106-113, 113 Stat. 1501 (1999). Since the amendment was made via § 401 of this legislation, a hospital which receives the new rural reclassification is often referred to a "§ 401" hospital.
[50] *Toledo* at *19.
[51] *Id.* at *19-20.
[52] *Id.* at *21.
[53] *Id.* at *22.
[54] *Id.* at *23-25.
[55] *Id.* at *29.

2. The Secretary's decision to not provide a capital DSH adjustment was arbitrary because:

   - "The Secretary has not put forth evidence that the agency took these costs into account, either in 1991, 2000, 2004, or 2006."[56]

   - "[T]he record does not show that the Secretary articulated a consistent policy of treating these reclassified hospitals as rural for capital DSH adjustment purposes, he cannot fall back on any purported general policy of using operating PPS geographic classifications for capital PPS reimbursements."[57]

   - "The Secretary also has not explained, even as a general matter, why classification uniformity outweighs the value of more accurate cost reimbursements. *Cf. Anna Jacques Hosp*., 797 F.3d at 1161 (upholding Secretary's regulation where the Secretary explained why 'added precision' 'would not justify the added complication') (quotation omitted)."[58]

   - "The agency cannot 'entirely fail[ ] to consider' the "relevant data" and the factors that Congress directed it to review. *State Farm*, 63 U.S. at 43. 103 S. Ct. 2856. Here, the Secretary did not perform a cost analysis to determine whether reclassified rural hospitals should receive a capital DSH adjustment, nor did he take costs into account at all."[59]

Notwithstanding these findings, the D.C. District Court declined to vacate 42 C.F.R. § 412.320(a)(1)(iii) because "vacatur of a rule is not an appropriate remedy on review of an adjudication."[60] Instead, the Court remanded the case to the Medicare Contractor for a redetermination on the appellants' eligibility for a capital DSH adjustment.[61]

CMS has since amended its regulations and, for discharges on or after October 1, 2023, urban hospitals that reclassified as rural are no longer "considered rural for purposes of determining eligibility for capital DSH payments."[62]

Providers' Request for EJR

As background, "[e]ach of the Providers is an acute care hospital paid by Medicare pursuant to the inpatient and capital [prospective payment systems]. During the years under appeal, the hospitals were all geographically located in urban areas, operated more than 100 beds, served

[56] *Id.*
[57] *Id.*
[58] *Id.*
[59] *Id.*
[60] *Id.* at *30.
[61] *Id.*
[62] 88 Fed. Reg. 58640, 59117 (Aug. 28, 2023); 42 C.F.R. § 412.103 (2024).

low-income patients and, for all or part of the year, received [§] 401 rural reclassifications pursuant to 42 C.F.R. § 412.103."[63]

The Providers are challenging the validity of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers assert that this regulation is inconsistent with the underlying operating PPS statute, in particular 42 U.S.C. § 1395ww(d)(8)(B), which states that hospitals that have undergone a rural reclassification are rural only for purposes of this subsection 1395ww(d). The Providers note that "[t]he capital PPS provisions located in an entirely different section of the statute, in 42 U.S.C. § 1395ww(g), and therefore a rural reclassification under the subsection (d) operating PPS provisions does not apply for subsection (g) capital PPS purposes."[64]

The Providers believe that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(g), and the regulation must be found invalid.[65] The Providers assert that "the Secretary has implicitly acknowledged that he cannot apply rural status for hospitals that have undergone a rural reclassification to payment provisions outside of subsection (d)," and provides as an example, that "the Secretary has stated with respect to direct graduate medical education ("GME") that no adjustment to the direct GME cap are available for urban hospitals that have reclassified as rural because subsection (d) reclassification 'affects only payments under section 1886(d) of the Act' and 'payments for direct GME are made under section 1886(h) of the Act.'"[66] Further, the regulation fails to take into account any variation in cost based on location, as the capital PPS statute permits at 42 U.S.C. § 1395ww(g)(1)(B)(ii).[67]

The Providers assert that "[t]he Secretary's adoption of the regulation was arbitrary and capricious and violates the Administrative Procedure Act" because he "failed to establish that adoption of the exception to the capital DSH adjustment, for providers that reclassified as rural, took 'into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located.'"[68]

Though 42 C.F.R. § 412.320(a)(1)(iii) has not been vacated, the Providers argue that the merits of their position were adopted by the D.C. District Court in *Toledo*.[69] Further, the Providers contend that the Secretary adopted the FY 2024 hospital IPPS proposed rule in which the Secretary, in response to *Toledo*, proposed to amend 42 C.F.R. § 412.320(a)(1)(iii). Specifically, effective for discharges occurring on or after October 1, 2023, an urban hospital that is reclassified as rural under § 412.103 "will no longer be considered rural for purposes of determining capital DSH eligibility. Instead, for purposes of § 412.320, the geographic

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[63] Request for EJR at 7.
[64] *Id.* at 1, 7.
[65] *See id.* at 7-8.
[66] *Id.* at 8 (citing 70 Fed. Reg. 47278, 47437 (Aug. 12, 2005)).
[67] *Id.*
[68] *Id.* at 8-9.
[69] *Id.* at 9-12.

classifications specified under § 412.64 will apply."[70] However, the Providers explain that "for the periods under appeal, CMS and its contractors will continue to apply the 2006 regulation, denying capital DSH to the Providers for these periods."[71]

The Providers further contend that since the Board is bound by the regulation being challenged,[72] namely, the validity of 42 C.F.R. § 412.320(a)(1)(iii), it lacks the authority to decide the legal question presented in the Providers' Request for EJR. Since the additional criteria for EJR have also been met, the Providers request the Board grant the request.[73]

Medicare Contractor's Response:

Following receipt of the Consolidated Request for EJR on **August 28, 2026**, the Medicare Contractor's representative, Federal Specialized Services ("FSS") filed a timely notice certifying that it would be filing Substantive Claim Challenges in Cases 25-5165G, 26-1073GC, and 25-5476G.[74] The next day, FSS filed an Amended Response which also indicated it would be filing a Substantive Claim Challenge in Case 25-5418G.[75] Both responses stated that FSS would not be filing Jurisdictional Challenges in any of the five (5) cases.[76] FSS, however, did not certify that it would file any challenges in Case 26-0297GC within the time required by the Board's Rules.[77]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

1. Jurisdiction

A group of Providers generally have a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if:

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[70] *Id.* at 10 (citing 88 Fed. Reg. 58640, 59117, 59334 (Aug. 28, 2023).
[71] *Id*.
[72] *See* 42 C.F.R. § 405.1867.
[73] Request for EJR at 10-12.
[74] Response to Provider's Request for Expedited Judicial Review (Sept. 3, 2026).
[75] Amended Response to Provider's Request for Expedited Judicial Review (Sept. 4, 2026).
[76] *Id.*
[77] Board Rule 44.5.2 (2023) typically requires a party questioning whether a participant included an appropriate claim on the cost report at issue to file its Substantive Claim Challenge within 60 days of the group filing its Final Schedule of Providers ("SOP"). When an EJR Request is filed within 60 days of the Final SOP, the moving party must certify that it will be filing a challenge within five business days and then must file the actual challenge within 20 days following the filing of the EJR Request. The Consolidated EJR Request in the case was filed on August 28, 2026. Any certifications of forthcoming challenges were due no later than September 5, 2026.

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [78]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[79]

The Providers in this case have appealed from original NPRs. Based on its review of the record, the Board finds that each of the participants in this group appeal filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835; that the providers appealed the issue in their respective appeals; and that the Board is not precluded by regulation or statute from reviewing the issue in these appeals. Finally, in each case, the amount in controversy meets the $50,000 threshold for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3).

2. Jurisdiction – Appropriate Cost Report Claim (FYEs On or After December 31, 2016)

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[80] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[81] The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement ("NPR") issued by the

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[78] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986). Medicare Contractors must issue an NPR within twelve months of receiving a Provider's perfected or amended cost report. Providers are afforded the right to appeal if this NPR is not timely received pursuant to 42 C.F.R. § 405.1835(c), which states:

> (1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped "Received" on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.
>
> (2) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) of this section) . . .

[79] 42 U.S.C. § 1395oo(a) and (b); 42 C.F.R. §§ 405.1835 – 1840.
[80] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[81] *Id.* at 70555.

Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction requirement"). Since all the participants in this case have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement for the Board's ***jurisdiction*** is not applicable.

3. Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. § 405.1873 (Cost Reports Beginning on or After January 1, 2016)

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are applicable. The regulation, 413.24(j) requires that:

> (1) In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), must include an appropriate claim for the specific item, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) Self-disallowance procedures. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and

> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, explaining why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and describing how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.

In conjunction with the regulation above, 42 C.F.R. § 405.1873(a) states:

> (a) *General*. In order to receive or potentially receive reimbursement for a specific item, the provider must include in its cost report an appropriate claim for the specific item (as prescribed in § 413.24(j) of this chapter). **If** the provider files an appeal to the Board seeking reimbursement for the specific item and **any party** to such appeal **questions whether the provider's cost report included an appropriate claim for the specific item**, the Board must address such question in accordance with the procedures set forth in this section.

These regulations are applicable to the cost reporting periods under appeal for all the participants in this group appeal, which all have cost reporting periods ending on or after December 31, 2016. The regulation at § 405.1873(b) sets out certain procedures that must be followed in the event a party questions whether the cost report included an appropriate claim for a specific item under appeal. *In such situations where a party raises that question*, the regulation requires the Board to give the parties an adequate opportunity to submit factual evidence and legal arguments regarding whether the provider's cost report included an appropriate claim for the specific item under appeal, and upon receipt of the factual evidence or legal argument (if any), the Board must review the evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[82] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[83] In this case, the Medicare Contractor failed to certify that it would be filing a Substantive Claim Challenge[84] within the time frame specified by Board Rule 44.6 (2023) for any of the Providers with FYEs December 31, 2016 or later.

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[82] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[83] *See* 42 C.F.R. § 405.1873(a).
[84] Board Rule 44.5 states: "The Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether *the cost report at issue* included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[85] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

4. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that the participants in this case are entitled to a hearing before the Board;

2) Board review of whether the Providers' cost reports included an appropriate claim for a specific item as required by 42 C.F.R. § 405.1873(a) has not been triggered;

3) Based upon the participants' assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), there are no findings of fact for resolution by the Board;

4) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

5) It is without the authority to decide the legal question of whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' EJR Request for the issue and the subject years in Case No. 26-0297GC. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the appeal is hereby closed and removed from the Board's docket.

[85] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole A. Musgrave, Esq.
Shakeba DuBose, Esq.
Clayton J. Nix, Esq.

FOR THE BOARD:

9/11/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: KEVIN D. SMITH -A

Enclosure: Schedule of Providers

cc: Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-L)
Scott Berends, Esq., FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

Floyd Perkins, Partner
Polales, Horton & Leonardi, LLP
53 West Jackson Blvd, Suite 1325
Chicago, IL 60604

RE: ***Board Determination on Provider's Renewed Motion to Vacate Dismissal & Motion to Reconsider Board's Denial of Provider's Motion to Vacate Dismissal & Reinstate the Case***

Case Number: 26-0163 ~ University of Illinois Hospital and Clinics (Provider Number 14-0150)
Fiscal Year Ended: 6/30/2020

Dear Mr. Perkins:

The Provider Reimbursement Review Board (the "Board") has reviewed the above-captioned appeal in response to the August 11, 2026 *Renewed Motion to Vacate Dismissal of this Case and Motion to Reconsider the Board's Denial of Provider's Motion to Vacate Dismissal of this Case and Reinstate the Case* ("Renewed Motion") filed by Polales, Horton & Leonardi, LLP ("PH &L"/ "Representative"). In its Renewed Motion, PH&L contends that the Board's July 22, 2026 decision did not address the Provider's argument citing 42 C.F.R. § 405.1868 (a) and (b), which require the Board to conduct an excusable neglect analysis to examine if dismissal of a case is an appropriate sanction. The pertinent facts regarding this case and the Board's determination are set forth below.

Pertinent Facts:

On **October 20, 2025**, PH&L filed the individual appeal for University of Illinois Hospital and Clinics ("Provider"), based on the April 23, 2025 "Notice of Program Reimbursement" ("NPR") for its fiscal year end ("FYE") 6/30/2020 under Case No. 26-0163.

On **October 29, 2025**, the Board issued a "Case Acknowledgement and Critical Due Dates Notice" ("ACCD") setting the Provider's preliminary position paper (*hereinafter "PPP"*) deadline for **June 17**, **2026,** and the Medicare Contractor's ("MAC's") PPP deadline for **October 15, 2026**.

On **June 22, 2026**, *five days after the expiration of the Provider's PPP deadline*, the Board dismissed Case No. 26-0163 pursuant to Board Rule 23.4, for the Provider's failure to timely file its PPP by the deadline.[1]

[1] Board Rules v. 3.2 (Dec. 2023).

On **June 23, 2026**, PH&L filed a Motion to Vacate the Dismissal and Reinstate the Appeal along with a copy of the Provider's PPP as required by Board Rule 47.3. In its Motion, PH&L acknowledged that its failure to meet the deadline "was entirely the result of an inadvertent and unintentional clerical data-entry error."[2] Although PH&L admitted that it mistakenly logged the wrong due date when it calendared the case on its internal docket, the Representative requested that the Board find good cause pursuant to 42 C.F.R. § 405.1868(b)(2). PH&L argued that, although dismissal and reinstatement are both at the Board's discretion, the decision to dismiss can be tempered by an excusable mistake standard. Therefore, PH&L requested that the Board find the "mis-dated" deadline be judged under an equitable determination that considers circumstances such as "prejudice to the opposing party, the length of delay, its potential impact on the proceedings, the reason for the delay, and whether the movant acted in good faith."[3]

On **July 22, 2026**, the Board denied the Provider's request for reinstatement citing Board Rule 47.1, which indicates the Board will not reinstate an appeal if the provider was at fault and Board Rule 47.3 which clarifies that, when the dismissal is based on the failure to comply with Board Procedures, the Board may reinstate for good cause which DOES NOT include administrative oversight.[4]

On **August 11, 2026**, the Representative filed a 26-page Motion requesting the Board to reconsider its reinstatement denial. PH&L contends that the Board's July 22, 2026 decision did not address the Provider's argument citing 42 C.F.R. § 405.1868 (a) and (b) which requires the Board to conduct an excusable neglect analysis to examine if dismissal of a case is an appropriate sanction. The Representative goes on to cite several cases, including a US Supreme Court decision in *Pioneer Investment Services Co. v. Brunswick Associates Ltd. Partnership*, 507 U.S. 380 (1993) ("*Pioneer*"). The Representative contends the *Pioneer* case establishes that, in exercising discretion to dismiss a case for a missed filing deadline, courts and tribunals must avoid arbitrary and capricious decisions, must meet due process, and must engage in an excusable neglect analysis, AND if the facts show an excusable neglect - the court or tribunal may not enter dismissal as a sanction. The Representative maintains that Board Rule 47, which the Board cited as the basis for denial of reinstatement, cannot override the relevant regulation or federal case law.[5] Accordingly, PH&L suggests a lesser sanction be applied in this case by shortening the time for the Provider's response and applying the extra days to the MAC's PPP deadline.[6]

Board Determination:

Pursuant to 42 U.S.C. §1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is

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[2] Motion to Vacate Dismissal and Reinstate this Appeal at 2 (June 23, 2026).
[3] *Id.*
[4] The Board's decision denying reinstatement referenced Rule 44 governing motions and also found PH&L's Motion to Reinstate to be deficient because it failed to include a statement confirming it had contacted the MAC prior to filing the motion to see if the MAC would concur or oppose the motion.
[5] Renewed Motion at 10-16.
[6] *Id.* at 3-4. The Representative also included a statement from the MAC in its renewed Motion which indicates the MAC opposes the motion to reinstate, deferring to the Board's July 22, 2026 decision not to vacate.

dissatisfied with the contractor's final determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the requires for hearing is filed within 180 days of the date of receipt of the final determination. Further, the Board is bound by the statutes and regulations, including those governing CIRPs, specifically 42 C.F.R. §405.1837(b)(1)(i) which requires that commonly owned or controlled providers file a single group for the same issue occurring in the same year.

The Board has reviewed PH&L's Renewed Motion requesting that the Board reconsider its denial of reinstatement in accordance with 42 C.F.R. § 405.1868(b) and to use its discretion to find excusable neglect is present. The Board has also reviewed PH&L's proposal that the Board grant a lesser sanction by rescheduling the remaining PPP deadlines in the case.

Despite PH&L's reliance on various cases in support of its argument that the Board must apply an excusable neglect standard prior to dismissal, the Courts have consistently recognized the Board's authority to dismiss cases for noncompliance with its rules or missed deadlines. One of the Representative's main arguments focuses on the 1993 Supreme Court decision in *Pioneer,* involving the application of a bankruptcy regulation. However, as discussed in the 2009 district court decision in *Kaiser Found. Hosps. v. Levitt*, No. 08-02129, 2009 WL 10678227 at n.7 (C.D. Cal. 2009) ("*Kaiser*"), the Board finds the decision in *Pioneer* is not applicable here. In *Kaiser*, footnote 7 confirms that the "excusable neglect" argument was unnecessary to resolve the issue, and the Board's enforcement of a missed deadline was considered a permissible exercise of its discretion. The ruling affirmed that administrative agencies are not required to apply equitable civil court standards to procedural deadlines, upholding the Board's authority to strictly enforce deadlines.

Moreover, the *Kaiser* decision cites to the 4th Circuit's decision in *Inova Alexandria Hosp. v. Shalala*, 244 F.3d 342, 347 (4th Cir. 2001) as being instructive on excusable neglect.[7] In that case, the Fourth Circuit found the Board's refusal to reinstate the Provider's appeal was not arbitrary or capricious as Inova's failure to file position papers was due to administrative oversight. While that decision was prior to the present iteration of Board Rule 47, the decision shows how Board Rule 47 complies with the excusable neglect standard.

After considering the Representative's arguments regarding excusable neglect, as well as its proposal for lesser sanctions, the Board again concludes that this is a straight-forward case of "administrative oversight." The Board requirements are consistent with 42 C.F.R. § 405.1853(b). Here, the Representative (which is not new to Board procedures) failed to follow the process set forth in the ACDD and Board Rules. In Board Rule 5.2, the responsibilities a representative is charged with include being familiar with Board Rules and deadlines and those Rules state that failure of the representative to carry out his/her responsibilities as a representative is not considered good cause for failing to meet filing deadlines.

In summary, pursuant to its authority under 42 C.F.R. § 405.1868(a)-(b), the Board DENIES the Provider's Renewed Motion and reaffirms its prior determination that the Provider was at fault and failed to establish good cause under Board Rules 47.1 and 47.3. Accordingly, the Board declines to exercise its discretion to reinstate Case No. 26-0163 and the case remains closed.

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[7] *See* also *Kaiser Found. Hosps*., 649 F.3d at 1160 (declining to apply excusable neglect equitable analysis to Board's dismissal of case for "failure to timely submit a position paper").

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Kevin D. Smith, CPA
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For the Board:

9/14/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: KEVIN D. SMITH -A

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Notice of Dismissal***
Lower Keys Medical Center, Prov. No. 10-0150, FYE 09/30/2022
Case No. 25-5164

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 25-5164. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 25-5164*

On **February 6, 2025**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2022.

On **July 28, 2025**, Community Health Systems, Inc. ("CHS"), the parent organization, filed an appeal on behalf of the Provider which included six issues:

1. DSH Pymt/SSI% (Provider Specific)[1]
2. DSH SSI Unduly Narrow Definition of SSI Entitlement[2]
3. DSH Pymt - Medicaid Eligible Days
4. Medicare Managed Care Part C Days – SSI & Medicaid Fractions[3]
5. Improper Ruling – SSI Dual Eligible Days[4]
6. Improper Ruling – Medicaid Fraction Dual Eligible Days[5]

Because the Provider is under common ownership it is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1).

[1] On March 24, 2026, this issue was withdrawn.
[2] On February 3, 2026, this issue was transferred to Case No. 26-1716GC.
[3] On February 3, 2026, this issue was transferred to Case No. 25-4631GC.
[4] On February 3, 2026, this issue was transferred to Case No. 25-4632GC.
[5] On February 3, 2026, this issue was transferred to Case No. 25-4633GC.

On **July 29, 2025**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter* "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[6]

On **July 29, 2025**, the Medicare Contractor ("MAC") uploaded a copy of a Request to the Provider for a DSH Package.

On **March 24, 2026**, the Provider timely filed its PPP and the MAC filed its PPP on **June 26, 2026**.

On **April 29, 2026**, CHS requested a change in representation to Quality Reimbursement Services, Inc. ("QRS"), which the Board granted the same day.

On **May 19, 2026**, the MAC filed a jurisdiction challenge over the Medicaid Eligible Days issue.

MAC's Contentions- Issue #3 - DSH – Medicaid Eligible Days

The MAC contends the Provider failed to file complete PPP including all supporting exhibits to document the merits of its argument and failed to properly develop its argument in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25.3. In addition, the Provider had not submitted an auditable listing of eligible days as required. Finally, the MAC objects to the Provider's attempt to untimely and improperly add the section 1115 waiver days issue by including it as a sub-issue in its PPP.[7]

Provider's Jurisdictional Response

Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."[8] The Provider failed to file a timely response by the *June 18, 2026* deadline.

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[6] (Emphasis added.)
[7] MAC's Jurisdictional Challenge at 2.
[8] Board Rule 44.4.3, v. 3.2 (Dec. 2023).

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby ***dismisses*** the Provider's sole remaining issue.

A. DSH Payment – Medicaid Eligible Days

The Provider did not include a list of the specific additional Medicaid eligible days that are in dispute in the initial appeal.

With regard to the filing of an individual appeal, Board Rule 7 - Support for Appealed Final Determination, Availability of Issue-Related Information and Basis for Dissatisfaction (Dec. 2023) states:

> **No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of PPs:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[9]

[9] (Bold emphasis added.)

The regulations require the parties to fully brief the merits of each issue in their PP (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Board Rule 25 (Dec. 2023) requires the Provider to file its complete, *fully* developed PPP with all available documentation and gives the following instruction on the content of PPs:

Rule 25 - Preliminary Position Papers[10]

> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the following sub-sections.

25.1.1 The Provider's Position Paper

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
D. Provide a conclusion applying the material facts to the controlling authorities.

25.2 Position Paper Exhibits

25.2.1 General

[10] (Underline emphasis added to these excerpts and all other emphasis in original.)

> With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.
>
> **25.2.2 Unavailable and Omitted Documents**
>
> If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.
>
> **25.2.3 List of Exhibits**
>
> Parties must attach a list of the exhibits exchanged with the position paper.
>
> **25.3 Filing Requirements to the Board**
>
> Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.
>
> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The July 29, 2025 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 3, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the

Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[11]

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On March 24, 2026, the Provider filed its PPP in which it indicated that the eligibility listing was imminent by promising that the [*auditable*] listing was being sent to the MAC under separate cover.[12] The Provider's complete briefing of this issue in its PPP is as follows:

> **Calculation of Medicaid Eligible Days**
>
> The Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.

[11] (Emphasis added.)
[12] Provider's PPP at 9.

The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).

The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:

> [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.

Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).

Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2022 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

> With respect to section 1115 waiver days, the courts have firmly rejected CMS's interpretation of its regulations, holding instead that the plain language of the statute and the regulations require inclusion in the Medicaid Fraction of the days belonging to individuals who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool. *See Forrest General Hospital,* 926 F.3d 221 (5th Cir. 2019); *HealthAlliance Hospitals, Inc. v. Azar*, 346 F. Supp. 3d 43(D.D.C. 2018); *Bethesda Health Inc., v. Azar*, 389 F. Supp. 3d 32, (D.D.C. 2019), *aff'd*, 980 F.3d 121 (D.C. Cir. 2020). CMS has acquiesced in *Bethesda* and is now following the statute and the plain meaning of its own regulations (which regulations represent the official policy of CMS all along) and properly accounting for 1115 Waiver days as Medicaid Eligible days. *See* CMS Manual Instructions System, Change Request 12669, Transmittal No. 11912 (March 16, 2023) ("Transmittal 11912"), attached as Exhibit P-3.[13]

In its May 19, 2026 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid Eligible days issue because the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its PPP. Moreover, the MAC contends that the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.[14]

The Board concurs with the MAC- that the Provider is required to identify *the material facts* (*i.e*., the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(4)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. the broad allegation that ". . . the total number of days reflected in its 2022 cost report does not reflect an accurate number of Medicaid eligible days . . ." The Provider failed to fully develop the merits of the Medicaid Eligible days issue because it failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue.

The Board recognizes that the Provider filed a redacted Eligible Days listing as an exhibit to its PPP, however:

---

[13] Provider's PPP at 8-10.

[14] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

1. An auditable version of the 12-page listing at Exhibit P-1 was not provided to the MAC;
2. The 12-page redacted listing shows roughly 1,284 "Additional ME Days" but includes the caveat "Listing pending finalization upon receipt of State eligibility data." There was no support accompanying the exhibit.
3. The Provider did not include an explanation as to why the first time it was filing the ME days listing was almost 3.5 years after the fiscal year at issue had closed and almost 8 months after the appeal was filed, nor did it explain why the listing was not yet final.

The Provider has essentially abandoned the Medicaid Eligible days issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.

B. Section 1115 Waiver Days

The Board has determined that the Section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added.[15] While the Provider appealed Medicaid Eligible days, this issue is separate and distinct from the Section 1115 Waiver days.

The appeal was filed with the Board in July of 2025 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[16]

Board Rule 7.2.1 (2023) elaborated on this regulatory requirement, instructing providers:

> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:

[15] *See, e.g.,* Board Rule 27.3 (Dec. 2023) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."
[16] 42 C.F.R. § 405.1835(b).

- the adjustment, including the adjustment number,
- the controlling authority,
- why the adjustment is incorrect,
- how the payment should be determined differently,
- the reimbursement effect, and
- the basis for jurisdiction before the [Board].

Board Rule 8 (Dec. 2023) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[17]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[18]

42 C.F.R. § 405.1835(e) provides in relevant part:

> (e) Adding issues to the hearing request. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
> . . .
> (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

In practice, this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider properly or timely added the Section 1115 Waiver days issue to the case.

In this regard, the Board notes that Section 1115 Waiver days are not traditional Medicaid Eligible days and, indeed, were only incorporated into the DSH calculation effective January 20, 2000.[19] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating

[17] (Bold and italic emphasis added).
[18] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[19] 65 FR 47054, 47087 (Aug. 1, 2000).

to Section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying Section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a Section 1115 Waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) (2019) states in pertinent part:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.**
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for **each** Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Because the Provider did not raise the Section 1115 Waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The Medicaid Eligible days issue as stated in the original appeal request cannot be construed to include Section 1115 Waiver days. Additionally, there is no indication that any Section 1115 Waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

Regardless, even if the Provider had included in its appeal request (***which it did not***), the Provider failed to properly develop the issue in its PPP filing. The PP does not identify the specific 1115 Waiver day program(s) at issue), nor does it discuss whether or not the Section 1115 Waiver days

at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the PPP is perfunctory in that it only makes cursory conclusions.[20] Again, the Provider failed to so develop its PPP, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 23 (Dec. 2023).

As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* Section 1115 Waiver days sub-issue.

The Board's finding that neither the appeal request nor the PPP met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[21] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[22] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[23] The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[24] Here, the Board makes the same finding based on similar *overly generalized language.*

* * * * *

[20] For example, QRS cites to *Forrest General Hosp.*, 926 F.3d 221 (5th Cir. 2019) for the proposition that "the plain language of the statute and regulations require inclusion in the Medicaid Fraction of the days belong to individual who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool." However, QRS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is QRS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? QRS fails to brief the merits of its claims and fails to establish the Board's jurisdiction over the § 1115 waiver day issue as required by 42 C.F.R. § 405.1853(b)(2). Indeed, the quoted sentence is the only time the PPP references "uncompensated care pool."
[21] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[22] *Id*. at *11.
[23] *Id.*
[24] *Id.*

Based on the foregoing, the Board dismisses the last remaining issue in this case – Medicaid Eligible days (Issue #3) including Section 1115 Waiver days. As no issues remain, the Board hereby closes Case No. 25-5164 and removes it from the Board's docket.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.
Clayton J. Nix. Esq.

For the Board:

9/14/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Blvd.
Mail Stop: B1-01-31
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Notice of Dismissal***
University of South Alabama Medical Center (Prov. No. 01-0087), FYE 09/30/2019
Case No. 24-1952

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 24-1952. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 24-1952*

On **December 21, 2023**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2019.

On **June 18, 2024**, the Board received the Provider's individual appeal request. The Appeal Request was filed by Quality Reimbursement Services, Inc. ("QRS") and included one issue: DSH Medicaid Eligible Days.

On **June 24, 2024**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter*, "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was

> made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[1]

On **February 12, 2025**, QRS filed the Provider's PPP and on **May 16, 2025**, the Medicare Contractor (MAC") filed its PPP.

On **May 28, 2025**, the MAC filed a Jurisdictional Challenge.

MAC's Contentions- DSH – Medicaid Eligible Days

The MAC contends that the Provider abandoned the Medicaid Eligible Days issue when it failed to include a list of additional Medicaid eligible days it expected to be included with its appeal or is PPP. Therefore, the PPP was not filed in accordance with Board Rule 25.2 and 42 CFR § 405.1853.

In addition, the MAC contends the Provider is attempting to untimely and improperly add the issue of Section 1115 waiver days via its PPP, filed on February 12, 2025. The MAC asserts that prior to the PPP, the Provider had not formally added the dispute to the appeal, nor had it otherwise raised the issue of Section 1115 waiver days.[2] Finally, the MAC argues that Section 1115 waiver days issue is one component of the DSH issue - and is a separate and distinct issue from Medicaid eligible days issue so it must be identified and appealed separately.[3]

Provider's Jurisdictional Response

Board Rule 44.4.3 requires that: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed on June 27, 2025.

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby ***dismisses*** the Provider's sole remaining issue.

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[1] (Emphasis added.)
[2] MAC Jurisdiction Challenge at 7.
[3] *Id.*at 9.

A. DSH Payment – Medicaid Eligible Days

The Provider did not include a list of the specific additional Medicaid eligible days that are in dispute in the initial appeal.

With regard to the filing of an individual appeal, Board Rule 7 - Support for Appealed Final Determination, Availability of Issue-Related Information and Basis for Dissatisfaction (Dec. 2023) states:

> **No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[4]

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Board Rule 25 (Nov. 2021) requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

[4] (Bold emphasis added.)

Rule 25 - Preliminary Position Papers[5]

> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the following sub-sections.

25.1.1 The Provider's Position Paper

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
D. Provide a conclusion applying the material facts to the controlling authorities.

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

[5] (Underline emphasis added to these excerpts and all other emphasis in original.)

> If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.
>
> **25.2.3 List of Exhibits**
>
> Parties must attach a list of the exhibits exchanged with the position paper.
>
> **25.3 Filing Requirements to the Board**
>
> Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.
>
> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The June 24, 2024 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with the Medicaid Eligible Days issue, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[6]

[6] (Emphasis added.)

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On February 12, 2025, the Provider filed its PPP in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.[7] Significantly, the PPP did ***not*** include *the material fact* of how many Medicaid Eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $142,835 based on an estimated 582 days). The Provider's complete briefing of this issue in its PPP is as follows:

> **Calculation of Medicaid Eligible Days**
>
> The Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid

[7] Provider's PPP at 8.

> percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover to the MAC (redacted listing to follow), the Provider contends that the total number of days reflected in its 2019 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[8]

In its May 28, 2025 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid Eligible days issue because the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional

[8] Provider's PP at 7-8.

Medicaid eligible days (or explain why such documentation is unavailable) with its appeal request or its PPP in violation of 42 CFR §405.1853 and Board Rule 25.3. Thus, the MAC asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the Board Rules.[9] In addition, the MAC indicated the Provider was attempting to untimely and improperly add the issue of Section 1115 waiver days by including the issue in its PPP. Furthermore, the MAC pointed out that, although the waiver days issue is a component of the Medicaid Eligible days issue, it is considered a separate issue.

The Board concurs with the MAC- that the Provider is required to identify *the material facts* (*i.e.*, the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(4)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid Eligible days issue because the provider failed to identify any specific Medicaid Eligible days at issue (much less any supporting documentation for those days) in either its appeal request or its PPP.

Although the Provider's PPP indicated a redacted listing would follow, the Provider failed to include a copy of the redacted listing as an Exhibit to the PPP. Pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[10] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its PPP filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the PPP filing (much less provider the § 412.106(b)(4)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

B. Section 1115 Waiver Days

The Board also concurs with the MAC, that the Section 1115 waiver days issue is not a part of this appeal as it was not properly or timely added. While the Provider appealed Medicaid Eligible days, this issue is separate and distinct from the Section 1115 waiver days.

The appeal was filed with the Board in June of 2024 and the regulations required the following:

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[9] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

[10] (Emphasis added.)

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[11]

Board Rule 7.2.1 (2023) elaborated on this regulatory requirement, instructing providers:

> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
> - the adjustment, including the adjustment number,
> - the controlling authority,
> - why the adjustment is incorrect,
> - how the payment should be determined differently,
> - the reimbursement effect, and
> - the basis for jurisdiction before the [Board].

Board Rule 8 (Nov. 2023) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[12]

[11] 42 C.F.R. § 405.1835(b).
[12] (Bold and italic emphasis added).

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[13]

42 C.F.R. § 405.1835(e) provides in relevant part:

> (e) Adding issues to the hearing request. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
> . . .
> (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

In practice, this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider properly or timely added the Section 1115 waiver days issue to the case.

In this regard, the Board notes that Section 1115 waiver days are not traditional Medicaid Eligible days and, indeed, were only incorporated into the DSH calculation effective January 20, 2000.[14] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 waiver days. Indeed, not every state Medicaid program has a qualifying Section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a Section 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) (2019) states in pertinent part:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the**

[13] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[14] 65 FR 47054, 47087 (Aug. 1, 2000).

> **Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.**
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for **each** Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Because the Provider did not raise the Section 1115 waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The Medicaid Eligible days issue as stated in the original appeal request cannot be construed to include Section 1115 waiver days. Additionally, there is no indication that any Section 1115 Waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

Regardless, even if the Provider had included in its appeal request (***which it did not***), the Provider failed to properly develop the issue in its PPP filing as it does not identify the specific 1115 waiver day program(s) at issue). In addition, the PPP does not discuss whether or not the Section 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the PPP is perfunctory in that it only makes cursory conclusions. Again, the Provider failed to so develop its PPP, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 23 (Dec. 2023).

As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* Section 1115 waiver days sub-issue.

The Board's finding that neither the appeal request nor the PPP met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of

Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[15] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[16] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[17] The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[18] Here, the Board makes the same finding based on similar *overly generalized language.*

* * * * *

Based on the foregoing, the Board dismisses the sole issue in this case – Medicaid Eligible days (including Section 1115 waiver days.) As no issues remain, the Board hereby closes Case No. 24-1952 and removes it from the Board's docket.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.
Clayton J. Nix. Esq.

For the Board:

9/14/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Cecile Huggins, Palmetto GBA (J-J)
Wilson Leong, FSS

[15] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[16] *Id*. at *11.
[17] *Id.*
[18] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Notice of Dismissal***
John Dempsey Hospital (07-0036), FYE 06/30/2019
PRRB Case No. 23-0027

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-0027. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 23-0027*

On **April 14, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2019.

On **October 5, 2022**, the Board received the Provider's individual appeal request. The Appeal Request was filed by Quality Reimbursement Services, Inc. ("QRS") and included six (6) issues:

1. SSI Provider Specific[1]
2. SSI Systemic Errors[2]
3. DSH Medicaid Eligible Days
4. SSI MCD PT C[3]
5. SSI MCD DUAL[4]
6. Standardized Payment Amount[5]

On **October 12, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter*, "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

[1] On July 20, 2026, this issue was withdrawn.
[2] On May 31, 2023, this issue was transferred to Case No. 23-0767G.
[3] On May 26, 2023, this issue was transferred to Case No. 23-0768G.
[4] On May 26, 2023, this issue was transferred to Case No. 23-0770G.
[5] On May 26, 2023, this issue was transferred to Case No. 22-1311G.

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[6]

On **May 31, 2023**, QRS filed the Provider's PPP and on **August 30, 2023**, the Medicare Contractor (MAC") filed its PPP.

On **October 9, 2023**, the MAC filed a Substantive Claim Challenge, followed by a Jurisdictional Challenge on **November 30, 2023**.

On **March 30 ,2026**, the Board issued a Notice of Hearing scheduling the case for a hearing date on **November 12, 2026**.

On **August 10, 2026,** QRS filed the Provider's final PP.

MAC's Contentions- DSH – Medicaid Eligible Days

The MAC contends that the Provider abandoned the Medicaid Eligible Days issue when it failed to include a list of additional Medicaid eligible days it expected to be included with its appeal or is PPP. Therefore, the PPP was not filed in accordance with Board Rule 25.2 and 42 CFR § 405.1853.

In addition, the MAC contends the Provider is attempting to untimely and improperly add the issue of Section 1115 waiver days via its PPP, filed on February 12, 2025. The MAC asserts that prior to the PPP, the Provider had not formally added the dispute to the appeal, nor had it otherwise raised the issue of Section 1115 waiver days.[7]

Provider's Jurisdictional Response

Board Rule 44.4.3 requires that: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed on December 30, 2023.

---

[6] (Emphasis added.)
[7] MAC Jurisdiction Challenge at 2, 14-15.

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby ***dismisses*** the Provider's sole remaining issue.

A. DSH Payment – Medicaid Eligible Days

The Provider did not include a list of the specific additional Medicaid eligible days that are in dispute in the initial appeal.

With regard to the filing of an individual appeal, Board Rule 7 - Support for Appealed Final Determination, Availability of Issue-Related Information and Basis for Dissatisfaction (Dec. 2023) states:

> **No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[8]

[8] (Bold emphasis added.)

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Board Rule 25 (Nov. 2021) requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

Rule 25 - Preliminary Position Papers[9]

> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the following sub-sections.

25.1.1 The Provider's Position Paper

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
D. Provide a conclusion applying the material facts to the controlling authorities.

25.2 Position Paper Exhibits

25.2.1 General

[9] (Underline emphasis added to these excerpts and all other emphasis in original.)

> With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.
>
> **25.2.2 Unavailable and Omitted Documents**
> If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.
>
> **25.2.3 List of Exhibits**
>
> Parties must attach a list of the exhibits exchanged with the position paper.
>
> **25.3 Filing Requirements to the Board**
>
> Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.
>
> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The October 12, 2022 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with the Medicaid eligible days issue, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the

percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[10]

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On May 31, 2023, the Provider filed its PPP in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.[11] Significantly, the PPP did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $56,371 based on an estimated 100 days). The Provider's complete briefing of this issue in its PPP is as follows:

[10] (Emphasis added.)
[11] Provider's PPP at 31.

Calculation of Medicaid Eligible Days

Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.

The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).

The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:

> [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.

Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).

> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its 2019 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[12]

In its November 30, 2023 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid eligible days issue because the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable) with its appeal request or its PPP in violation of 42 CFR §405.1853 and Board Rule 25.3. Thus, the MAC asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the Board Rules.[13] In addition, the MAC indicated the Provider was attempting to untimely and improperly add the issue of Section 1115 waiver days by including the issue in its PPP.

The Board concurs with the MAC- that the Provider is required to identify *the material facts* (*i.e*., the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(4)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days) in either its appeal request or its PPP.

Although the Provider's PPP indicated a redacted listing would follow, the Provider failed to include a copy of the redacted listing as an Exhibit to the PPP. Pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[14] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its PPP filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the PPP filing (much less provider the § 412.106(b)(4)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

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[12] Provider's PPP at 30-31.
[13] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.
[14] (Emphasis added.)

B. Section 1115 Waiver Days

The Board also concurs with the MAC, that the Section 1115 waiver days issue is not a part of this appeal as it was not properly or timely added. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from Section 1115 waiver days.

The appeal was filed with the Board in October of 2022 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[15]

Board Rule 7.2.1 (Nov. 2021) elaborated on this regulatory requirement, instructing providers:

> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
>   - the adjustment, including the adjustment number,
>   - the controlling authority,
>   - why the adjustment is incorrect,
>   - how the payment should be determined differently,
>   - the reimbursement effect, and
>   - the basis for jurisdiction before the [Board].

Board Rule 8 (Nov. 2021) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

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[15] 42 C.F.R. § 405.1835(b).

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[16]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[17]

42 C.F.R. § 405.1835(e) provides in relevant part:

> (e) Adding issues to the hearing request. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
> . . .
> (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

In practice, this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider properly or timely added the Section 1115 waiver days issue to the case.

In this regard, the Board notes that Section 1115 waiver days are not traditional Medicaid eligible days and, indeed, were only incorporated into the DSH calculation effective January 20, 2000.[18] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 waiver days. Indeed, not every state Medicaid program has a qualifying Section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a Section 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) (2019) states in pertinent part:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and

[16] (Bold and italic emphasis added).
[17] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[18] 65 FR 47054, 47087 (Aug. 1, 2000).

> divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.**
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for **each** Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Because the Provider did not raise the Section 1115 waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The Medicaid eligible days issue as stated in the original appeal request cannot be construed to include Section 1115 waiver days. Additionally, there is no indication that any Section 1115 Waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

Regardless, even if the Provider had included in its appeal request (***which it did not***), the Provider failed to properly develop the issue in its PPP filing as it does not identify the specific 1115 waiver day program(s) at issue). In addition, the PPP does not discuss whether or not the Section 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the PPP is perfunctory in that it only makes cursory conclusions. Again, the Provider failed to so develop its PPP, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 23 (Nov. 2021).

As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each

claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* Section 1115 waiver days sub-issue.

The Board's finding that neither the appeal request nor the PPP met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[19] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[20] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[21] The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[22] Here, the Board makes the same finding based on similar *overly generalized language.*

* * * * *

Based on the foregoing, the Board dismisses the sole issue in this case – Medicaid eligible days (including Section 1115 waiver days.) As no issues remain, the Board hereby closes Case No. 23-0027 and removes it from the Board's docket.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.
Clayton J. Nix. Esq.

For the Board:

9/14/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Danelle Decker, Wellpoint Federal Solutions, Inc. (J-K)
Wilson Leong, FSS

[19] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[20] *Id*. at *11.
[21] *Id.*
[22] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Blvd.
Mail Stop: B1-01-31
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Notice of Dismissal***
Southside Regional Medical Center (49-0067), FYE 02/28/2019, Case No. 23-0755

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-0755. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal: Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 23-0755*

On **August 19, 2022,** the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end February 28, 2019.

On **February 2, 2023**, the Board received the Provider's individual appeal request. The appeal, filed by Community Health Systems, Inc. ("CHS") included seven (7) issues[1]:

1. DSH Payment/SSI Percentage (Provider Specific)[2]
2. DSH/SSI – Unduly Narrow Definition of SSI Entitlement[3]
3. DSH Payment – Medicaid Eligible Days
4. Medicare Managed Care Part C – SSI and Medicaid Fractions[4]
5. SSI Fraction Dual Eligible Days[5]
6. Properly Offset the CHS Tuition Waivers[6]

[1] On December 8, 2023, the Board agreed to bifurcate the SSI & Medicaid Fraction Dual Eligible ("DE") Days issue into separate "fraction specific" issues. The SSI Fraction DE Days was left at issue #5 and the Medicaid Fraction DE days issue was created as issue #8.
[2] On July 20, 2026, this issue was withdrawn.
[3] On August 7, 2023, this issue was transferred to an SSI Percentage group, PRRB Case No. 22-1031GC. On August 4, 2026, the Board denied the transfer. Subsequently, on August 5, 2026 the issue was transferred to the Unduly Narrow CIRP group, PRRB Case No. 26-2711GC.
[4] On August 7, 2023, this issue was transferred to PRRB Case No. 23-0078GC.
[5] On December 20, 2023, this issue was transferred to PRRB Case No. 22-1006GC
[6] On July 24, 2026, this issue was withdrawn.

7. Additional Other Income - Nursing School[7]
8. Medicaid Fraction Dual Eligible Days[8]

The remaining issue in this appeal is Issue No. 3.

On **February 2, 2023**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter* "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 25.[9]

On **February 8, 2023**, the Medicare Contractor ("MAC") uploaded a copy of its request to the Provider for a DSH Package.

On **September 25, 2023**, the Provider filed its PPP.

On **November 28, 2023**, Quality Reimbursement Services, Inc. ("QRS") became the authorized representative for Case No. 23-0755. On the same date, QRS uploaded a "Supplement To Position Paper/Redacted Medicaid Eligible Days."

On **December 28, 2023**, the MAC filed a jurisdictional challenge.

On **January 16, 2024,** the MAC filed its PPP.

On **April 3, 2026**, the Board scheduled Case No. 23-0755 for a hearing on **October 27, 2026**.

On **July 27, 2026** and **August 19, 2026**, the Provider and MAC filed their respective final PPs.

B. ***Description of Issue 3 in the Appeal Request***

In its Individual Appeal Request, the Provider questions whether the MAC properly excluded Medicaid eligible days from the DSH calculation. The Statement of the Legal Basis is as follows:

---

[7] On July 24, 2026, this issue was withdrawn.
[8] On December 20, 2023, this issue was transferred to PRRB Case No. 23-0079GC
[9] (Emphasis added).

> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 13, 14, 16, S-D
> Estimated Reimbursement Amount: $109,522[10]

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[11] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[12]

The Provider goes on to state:

> Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's [or Providers'] Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's [or Providers'] Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its 2019 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and

[10] Appeal Request at Issue 3.
[11] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[12] Provider's PPP at 9.

the pertinent Federal Court decisions.[13]

MAC's Contentions - Issue 3 – Medicaid Eligible/Section 1115 Waiver Days

The MAC contends that the Provider abandoned the Medicaid eligible days issue when it failed to include a list of additional Medicaid eligible days it expected to be included with its appeal, nor did it submit a list with its PPP in accordance. Therefore, the PPP was not filed in accordance with Board Rule 25.3 and 42 CFR § 405.1853.[14]

In addition, the MAC contends the Provider is attempting to untimely and improperly add the issue of Section 1115 waiver days as a sub-issue via its PPP, filed on October 2, 2023. The MAC asserts that prior to the PPP, the Provider had not formally added the dispute to the appeal, nor had it otherwise raised the issue of Section 1115 waiver days.[15] The MAC contends that the Provider's attempt to add the issue within its PPP is improper and untimely, citing 42 C.F.R. § 405.1835(e), which governs when specific Medicare payment issues may be added to the original hearing request, including a timeframe of no later than 60 days after the expiration of the applicable 180-day deadline to file an appeal.[16] Finally, the MAC argues that Section 1115 waiver days issue is one component of the DSH issue - and is a separate and distinct issue from Medicaid eligible days issue so it must be identified and appealed separately.[17]

Provider's Jurisdictional Response

Board Rule 44.4.3 requires that: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed on January 27, 2024.

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby ***dismisses*** the Provider's Medicaid eligible days issue.

---

[13] *Id*. at 9-10.
[14] MAC Jurisdiction Challenge at 11.
[15] *Id* at 13.
[16] *Id*.
[17] *Id*.at 15-16.

A. DSH Payment – Medicaid Eligible Days

1. *Medicaid Eligible Days*

The Provider did not include a finalized list of the specific additional Medicaid eligible days that are in dispute in this case in either the initial appeal or the PPP.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Nov. 2021) states:

> **No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[18]

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Board Rule 25 (Nov. 2021) requires the Provider to file its complete, *fully* developed PPP with all available documentation and gives the following instruction on the content of position papers:

[18] (Bold emphasis added.)

Rule 25 Preliminary Position Papers[19]

> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the following sub-sections.

25.1.1 The Provider's Position Paper

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
D. Provide a conclusion applying the material facts to the controlling authorities.

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

[19] (Underline emphasis added to these excerpts and all other emphasis in original.)

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to the Board

Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The February 2, 2023 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 3, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this

> paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[20]

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On September 25, 2023, the Provider filed its PPP paper in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.[21] Significantly, the PPP did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather the exhibit at P-2 continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $109,522- which according to the issue statement filed with the appeal, was based on an estimated 200 days). The Provider's complete briefing of this issue in its PPP is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.

[20] (Emphasis added.)
[21] Provider's PPP at 10.

The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).

The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:

> [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.

Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's [or Providers'] Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's [or Providers'] Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).

Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2019 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[22]

[22] Provider PPP at 9-10.

In its December 28, 2023 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid eligible days issue because the Provider abandoned the issue. The Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable). Therefore, the Provider failed to file a complete PPP in violation of Board Rule 25 and 42 C.F.R.§ 405.1853.[23] As noted, the Provider failed to respond to the Jurisdictional Challenge within the 30-day time period, which expired on January 27, 2024.

After review, the Board concurs with the MAC, that the Provider is required to identify *the material facts* (*i.e*., the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(4)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days) in either its appeal request or its PPP.

Further, the Board rejects the Provider's attempt to "Supplement" the PPP by filing a Redacted Eligible Days listing on November 28, 2023 because:

1. The listing was filed past the deadline for the exhibits to be included with the PPP filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)) (***which was due on September 30, 2023***).

2. Given that the *material* facts (*e.g*., the days at issue) and all available exhibits were required to be part of the PPP, if the Board were to accept the November 28, 2023 listing of days (an auditable copy of which the MAC asserts it does not have), it would need to be either be a *refinement* of its PPP or a supplement of documents that were identified in the PPP as being unavailable consistent with Board Rule 25.2.2. However, neither the PPP nor the subsequent listing identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the redacted listings cannot be considered a refinement of the PPP since no specific days or listing were included with the PPP.[24]

---

[23] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

[24] *See, e.g.,* Board Rule 27.3 (Nov. 2021) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."

3. Finally, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[25] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its PP filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the PPP filing (much less provider the § 412.106(b)(4)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

2. *Section 1115 Waiver Days*

The Board finds that the Section 1115 waiver days issue is not a part of this appeal as it was not included as a cost issue in the appeal, nor was it properly or timely added. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from Section 1115 waiver days.

The appeal was filed with the Board in February of 2023 and the regulations required the following:

> b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) how and why the provider believes Medicare payment must be determined differently for each disputed item…[26]

Board Rule 7.2.1 (Nov. 2021) elaborated on this regulatory requirement instructing providers:

> The following information and supporting document must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:

[25] (Emphasis added.)
[26] 42 C.F.R. § 405.1835(b).

- the adjustment, including the adjustment number,
- the controlling authority,
- why the adjustment is incorrect,
- how the payment should be determined differently,
- the reimbursement effect, and
- the basis for jurisdiction before the Board.[27]

Board Rule 8 (Nov. 2021) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these examples are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include…***Section 1115 waiver days (program/waiver specific)***[28]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[29]
42 C.F.R. § 405.1835(e) provides in relevant part:

> (c) *Adding issues to the hearing request*. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
> . . .
>
> (2) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

In practice this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider properly or timely added the Section 1115 waiver days issue to the case.

In this regard, the Board notes that Section 1115 waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20,

[27] v. 3.1 (Nov. 2021).
[28] (Bold and italic emphasis added).
[29] *See* 73 Fed. Reg. 30190 (May 23, 2008).

2000.[30] Rather, they relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program ***and*** not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction.[20] In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) (2019) states in pertinent part:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act**.
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Because the Provider did not raise the Section 1115 waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The Medicaid eligible days issue as stated in the original appeal request cannot be construed to include Section 1115 waiver days. Additionally, there is no indication that any Section 1115 waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

---

[30] 65 FR 47054, 47087 (Aug. 1, 2000).

Regardless, even if the Provider had included the Section 1115 waiver days issue in its appeal request (which it did not), the Provider failed to properly develop the issue in its PPP filing. The Provider's PPP does not identify the specific 1115 waiver day program(s) at issue) notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (2021). Pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* Section 1115 waiver days sub-issue.

The Board's finding that neither the appeal request nor the PPP met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[31] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[32] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[33] The Court found that this description of the issue was a violation of Board rules and a proper basis for the Board to dismiss the appeal.[34] Here, the Board makes the same finding based on similar *overly generalized language*.

Based on the above, the Board finds that ***the appeal did not include the alleged Section 1115 waiver days sub-issue*** consistent with 42 C.F.R. §§ 405.1835(b)(2)-(3), 412.106(b)(4)(iii), and 405.1871(a)(3) and Board Rules 7.1, 8, 25, and 27.2.[35] In the alternative, the Board finds that, even if it had been included as part of the appeal, the issue was not properly developed in the PPP process.

* * * *

[31] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[32] *Id*. at *11.
[33] *Id.*
[34] *Id.*
[35] If section 1115 waiver days were found to be part of the appeal request and had been properly briefed, the Board would still need to address an additional jurisdictional issue – review whether it had jurisdiction over the section 1115 waiver days. For example, the Board has found that when a class of days (*e.g*., 1115 waiver days) is excluded due to choice, error, and/or advertence from the as-filed cost report, then that class of days is an unclaimed cost for which the Board would lack jurisdiction under 42 U.S.C. § 1395oo(a). *See, e.g.,* PRRB Jurisdictional Decision, Case Nos. 06-1851, 061852 (Nov. 17, 2017) (dismissing the class of adolescent psychiatric days from the appeal because no days were claimed with the as-filed cost report due to choice, error and/or inadvertence and, as such, the practical impediment standard or futility concept in the *Norwalk* and *Danbury* Board decisions is not applicable).

Based on the foregoing, the Board is dismissing the Medicaid eligible days (including the Section 1115 Waiver Days) issue in this case. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.
Clayton J. Nix, Esq.

For the Board:

9/14/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Byron Lamprecht, WPS Government Health Admin. (J-5)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Blvd.
Mail Stop: B1-01-31
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

Dena Pearson
1st Texas Home Health
4004 Call Field Road
Wichita Falls, TX 76306

Charles Moreland
Federal Specialized Services
1701 S. Racine Avenue
Chicago, IL 60608

RE: ***Board Decision re: Scheduling Order***
1st Texas Home Health (Provider Number 67-9027)
Case Number: 25-4324

Dear Ms. Pearson and Mr. Moreland:

On September 2, 2026, the Provider Reimbursement Review Board ("Board" or "PRRB") issued a decision denying the Medicare Contractor's Motion to Dismiss the appeal and ordered the parties to respond to the Board's scheduling order by September 11, 2026.[1]

On September 10, 2026, the Provider filed a request for a record hearing, and states:

> 1st Texas Home Health respectfully requests that the PRRB permit this matter to proceed based upon the documentary record and any additional records or stipulations requested or permitted by the Board.[2]

On September 11, 2026, the Medicare Contractor filed a response, stating:

> Counsel for the MAC has repeatedly contacted the Provider by email in an effort to arrange a record hearing. The Provider has not responded to those requests or otherwise cooperated for the purposes of presenting stipulations of fact or requesting a record hearing.[3]

To date, no stipulations of fact have been filed as part of the record.

As documented in the Board's September 2, 2026 decision to deny the Medicare Contractor's Motion to Dismiss, the Board takes note that the Provider:

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[1] Clarification Re: Board Decision on Motion to Dismiss and Scheduling Order (Sept. 8, 2026).
[2] Provider's *Request to Proceed By Record Request / Record Review* at 2 (Sept. 10, 2026).
[3] Medicare Contractor's *Response to Motion to Dismiss Decision and Scheduling Order* at 1 (Sept. 11, 2026).

(a) Failed to respond to the Medicare Contractor's July 17, 2026 Motion to Dismiss. Board Rule 44.3 makes clear that "an opposing party may file a response [to a motion], with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party." In this case, the Provider did not respond within the 30 days.

(b) Failed to file a witness list by the August 22, 2026 Deadline. Board Rule 28 states "[a]t least thirty (30) days prior to the hearing date, each party must file with the Board and serve on the opposing party a witness list." In this case, the Medicare Contractor filed a notification that it would not be presenting any witnesses on August 24, 2026. 1st Texas Home Health did not file any notification or witness list before the deadline, violating Board Rule 28.

(c) Failed to timely file a request for an alternative forum for the hearing thirty days prior to the hearing date. The Board's Notice of Hearing, sent to the parties on May 6, 2026, stated that "The Board will consider conducting a video hearing, record hearing, or telephonic hearing either on its own motion, or ***if a request from the parties is filed no later than 30 days prior to the scheduled hearing date***."[4] Additionally, the Board's decision letter, sent to the parties on September 2, 2026, clearly stated "[a]s the opportunity to submit a request for an alternative forum for the hearing ***has expired***, the Board will expect the parties to appear, in person."[5] Inexplicably, 1st Texas then filed, on September 10, 2026, a request for a record hearing. Board Rule 32.4 states:

> [i]n cases involving only legal interpretation or very limited fact disputes, and ***where both parties agree that the case is appropriate for record hearing***, the Board ***may*** approve the parties' request to submit their case only on the existing written record. . . .***The Board generally will deny the parties' request for a record hearing if stipulations regarding all undisputed facts and principles of law are not submitted with the parties' request***."[6]

1st Texas' request was untimely filed, did not indicate if the opposing party was in agreement with the request, and did not include any stipulations of fact, violating Board Rule 32.4.

(d) Failed to sufficiently respond to the Board's September 2, 2026 scheduling order. The Board specifically stated in the September 2, 2026 scheduling order that:

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[4] (Bold and italics emphasis added.)
[5] *Board Decision Re: Motion to Dismiss and Scheduling Order* at 8 (Sept. 2, 2026) (Bold and italics emphasis added).
[6] (Bold and italics emphasis added.)

> the Board will expect the parties to appear, in person . . . at 9 a.m. on Monday September 21, 2026. The parties must respond to this letter, in OH CDMS, . . . indicating they intend to appear. In accordance with 42 C.F.R. § 405.1868, failure of the party to respond by the deadline will result in abandonment and dismissal of the case with prejudice."

Instead, 1st Texas supplied a late request for a hearing on the record without countersigned stipulations of fact.

The Board finds that 1st Texas repeatedly missed its deadlines or failed to respond to the Medicare Contractor or to the Board. Indeed, even the original appeal was incomplete, and the Board staff provided opportunity for the Provider to supplement the record and bring its filings into compliance. 1st Texas has not made itself familiar with the Board's Rules, as required for all representatives. This is not a one-time occurrence, which the Board finds frustrating. The Provider has failed multiple times to follow instructions, be they in the Board Rules or in direct communications from the Board.

Accordingly, the Board hereby *denies* the Provider's request for a hearing on the record, which was submitted to the Board on September 10, 2026, as the request was untimely, coming eleven (11) days before the hearing and because no stipulations have been submitted. The hearing will remain as a live, in person hearing at 7111 Security Boulevard, Suite 120, Baltimore, MD 21244 at 9 a.m. EST on Monday, September 21, 2026, ***unless*** **the Provider properly completes both of the following requirements**:

(1) Contacts Federal Specialized Services ("FSS") immediately and works together to create joint stipulations of fact to support the September 10, 2026 request for a hearing on the record.
(2) Responds to this letter filing the necessary joint stipulations of fact or acknowledges that no stipulations will be filed and they will attend the in person hearing scheduled for Monday, September 21, 2026 at 7111 Security Boulevard, Suite 120, Baltimore, MD 21244 at 9 a.m. EST.

The Provider must file in OH CDMS by 5 p.m. EST on Thursday, September 17th. In accordance with 42 C.F.R. § 405.1868, failure of the Provider to respond by the deadline will result in dismissal of the case. No further leniency will be granted.

Moreover, as the Provider has failed to timely respond to any earlier Board set deadlines, as referenced above, the Board hereby denies any additional documentation, other than stipulations from the parties, and no further additions will be allowed or considered.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.
Clayton J. Nix, Esq.

For the Board:

9/15/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: KEVIN D. SMITH -A

cc: Dana Johnson, Palmetto GBA c/o Wellpoint Federal Solutions, Inc. (J-M)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244
410-786-2671

September 16, 2026

James Ravindran
President
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

Byron Lamprecht
Supervisor - Cost Report Appeals
WPS Government Health Administrators (J-5)
1000 N 90th Street, Suite 302
Omaha, NE 68114-2708

RE: Transfer Denial of Unduly Narrow Entitlement issue to SSI Percentage CIRP 22-1031GC-REINSTATEMENT
Santa Rosa Medical Center
Provider Number: 10-0124
Appealed Period: FYE 05/31/2019
PRRB Case Number: 23-0253

Dear Mr. Ravindran and Mr. Lamprecht:

On June 9, 2023, Community Health Systems, Inc. ("CHS") requested the transfer of an issue categorized as "DSH/SSI-Unduly Narrow Definition of SSI Entitlement" ("Unduly Narrow"/Issue #2) from the subject individual appeal for Santa Rosa Medical Center (Prov. No. 10-0124) to the "CHS CY 2019 DSH SSI Percentage CIRP Group," Case No. 22-1031GC. Based on the Group Issue statement, the providers in the group are appealing the SSI Systemic Errors issue as discussed in Baystate Med. Ctr. v. Leavitt case ("Baystate").

BOARD DETERMINATION:

42 C.F.R. § 405.1837(b)(i) requires that two or more providers under common ownership or control appealing a COMMON issue for cost reports ending in the same calendar year must bring the appeal in the group format. (Emphasis added). For purposes of the transfer of the Provider's “Unduly Narrow” issue (#2) to the “CHS 2019 DSH SSI Percentage CIRP Group”- Case No. 22-1031GC, the Board finds that the Provider appealed a distinctly different issue in its individual appeal than the issue under appeal in the group case. The Unduly Narrow issue relates to the exclusion of unpaid SSI days from the Medicare Fraction numerator. The Provider's issue statement for this issue discusses the definition/interpretation of the word "entitled," and cites to the Supreme Court’s Empire Health Found. v Becerra, 142 S. Ct. 2354 (2022) ("Empire case"). Conversely the SSI Percentage group issue in Case No. 22-1031GC relates to the SSI Accuracy/Baystate issue, in that it clearly addresses the SSI data matching process and the potential errors in that process.

Because the Unduly Narrow issue which is related to the Empire decision (regarding entitlement to paid and unpaid Part A days) is not the same issue described in the SSI Percentage group which is related to the Baystate issue, the Board DENIES the transfer of Issue #2 from Case No. 23-0253 to Case No. 22-1031GC. Case No. 23-0253 is being reinstated to pursue the Unduly Narrow issue.

The Board notes that, on June 15, 2026, QRS filed a "CHS CY 2019 SSI Unduly Narrow Definition of SSI

Entitlement CIRP CIRP Group" under Case No. 26-2711GC which was later expanded to include CY 2018. Because a CIRP provider is required to pursue a common issue with related providers in a group, within 15 days of this notice, the Provider must effectuate a transfer of the Unduly Narrow issue to the CHS Unduly Narrow CIRP group, Case No. 26-2711GC or the issue may be dismissed from this case.

Board Members Participating:
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.
Clayton J. Nix, Esq.

FOR THE BOARD:



Clayton J. Nix, Esq.
Board Member

cc: Wilson C. Leong, Federal Specialized Services
Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-H)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
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September 16, 2026

James Ravindran
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Arcadia, CA 91006

Byron Lamprecht
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1000 N 90th Street, Suite 302
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RE: Transfer Denial of Unduly Narrow Entitlement issue to SSI Percentage CIRP 22-1031GC-REINSTATEMENT
Alliance Health Woodward
Provider Number: 37-0002
Appealed Period: FYE 05/31/2019
PRRB Case Number: 23-0420

Dear Mr. Ravindran and Mr. Lamprecht:

On July 14, 2023, Community Health Systems, Inc. ("CHS") requested the transfer of an issue categorized as "DSH/SSI-Unduly Narrow Definition of SSI Entitlement" ("Unduly Narrow"/Issue #2) from the subject individual appeal for Alliance Health Woodward (Prov. No. 37-0002) to the "CHS CY 2019 DSH SSI Percentage CIRP Group," Case No. 22-1031GC. Based on the Group Issue statement, the providers in the group are appealing the SSI Systemic Errors issue as discussed in Baystate Med. Ctr. v. Leavitt case ("Baystate").

BOARD DETERMINATION:

42 C.F.R. § 405.1837(b)(i) requires that two or more providers under common ownership or control appealing a COMMON issue for cost reports ending in the same calendar year must bring the appeal in the group format. (Emphasis added). For purposes of the transfer of the Provider's “Unduly Narrow” issue (#2) to the “CHS 2019 DSH SSI Percentage CIRP Group”- Case No. 22-1031GC, the Board finds that the Provider appealed a distinctly different issue in its individual appeal than the issue under appeal in the group case. The Unduly Narrow issue relates to the exclusion of unpaid SSI days from the Medicare Fraction numerator. The Provider's issue statement for this issue discusses the definition/interpretation of the word "entitled," and cites to the Supreme Court’s Empire Health Found. v Becerra, 142 S. Ct. 2354 (2022) ("Empire case"). Conversely the SSI Percentage group issue in Case No. 22-1031GC relates to the SSI Accuracy/Baystate issue, in that it clearly addresses the SSI data matching process and the potential errors in that process.

Because the Unduly Narrow issue which is related to the Empire decision (regarding entitlement to paid and unpaid Part A days) is not the same issue described in the SSI Percentage group which is related to the Baystate issue, the Board DENIES the transfer of Issue #2 from Case No. 23-0420 to Case No. 22-1031GC. Case No. 23-0420 is being reinstated to pursue the Unduly Narrow issue.

The Board notes that, on June 15, 2026, QRS filed a "CHS CY 2019 SSI Unduly Narrow Definition of SSI

Entitlement CIRP CIRP Group" under Case No. 26-2711GC which was later expanded to include CY 2018. Because a CIRP provider is required to pursue a common issue with related providers in a group, within 15 days of this notice, the Provider must effectuate a transfer of the Unduly Narrow issue to the CHS Unduly Narrow CIRP group, Case No. 26-2711GC or the issue may be dismissed from this case.

Board Members Participating:
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.
Clayton J. Nix, Esq.

FOR THE BOARD:



Clayton J. Nix, Esq.
Board Member

cc: Wilson C. Leong, Federal Specialized Services
Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-H)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244
410-786-2671

September 16, 2026

James Ravindran
President
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

Byron Lamprecht
Supervisor - Cost Report Appeals
WPS Government Health Administrators (J-5)
1000 N 90th Street, Suite 302
Omaha, NE 68114-2708

RE: Transfer Denial of Unduly Narrow Entitlement issue to SSI Percentage CIRP 22-1031GC-REINSTATEMENT
Abilene Regional Medical Center
Provider Number: 45-0558
Appealed Period: FYE 08/31/2019
PRRB Case Number: 23-0278

Dear Mr. Ravindran and Mr. Lamprecht:

On June 9, 2023, Community Health Systems, Inc. ("CHS") requested the transfer of an issue categorized as "DSH/SSI-Unduly Narrow Definition of SSI Entitlement" ("Unduly Narrow"/Issue #2) from the subject individual appeal for Abilene Regional Medical Center (Prov. No. 45-0558) to the "CHS CY 2019 DSH SSI Percentage CIRP Group," Case No. 22-1031GC. Based on the Group Issue statement, the providers in the group are appealing the SSI Systemic Errors issue as discussed in Baystate Med. Ctr. v. Leavitt case ("Baystate").

BOARD DETERMINATION:

42 C.F.R. § 405.1837(b)(i) requires that two or more providers under common ownership or control appealing a COMMON issue for cost reports ending in the same calendar year must bring the appeal in the group format. (Emphasis added). For purposes of the transfer of the Provider's “Unduly Narrow” issue (#2) to the “CHS 2019 DSH SSI Percentage CIRP Group”- Case No. 22-1031GC, the Board finds that the Provider appealed a distinctly different issue in its individual appeal than the issue under appeal in the group case. The Unduly Narrow issue relates to the exclusion of unpaid SSI days from the Medicare Fraction numerator. The Provider's issue statement for this issue discusses the definition/interpretation of the word "entitled," and cites to the Supreme Court’s Empire Health Found. v Becerra, 142 S. Ct. 2354 (2022) ("Empire case"). Conversely the SSI Percentage group issue in Case No. 22-1031GC relates to the SSI Accuracy/Baystate issue, in that it clearly addresses the SSI data matching process and the potential errors in that process.

Because the Unduly Narrow issue which is related to the Empire decision (regarding entitlement to paid and unpaid Part A days) is not the same issue described in the SSI Percentage group which is related to the Baystate issue, the Board DENIES the transfer of Issue #2 from Case No. 23-0278 to Case No. 22-1031GC. Case No. 23-0278 is being reinstated to pursue the Unduly Narrow issue.

The Board notes that, on June 15, 2026, QRS filed a "CHS CY 2019 SSI Unduly Narrow Definition of SSI

Entitlement CIRP CIRP Group" under Case No. 26-2711GC which was later expanded to include CY 2018. Because a CIRP provider is required to pursue a common issue with related providers in a group, within 15 days of this notice, the Provider must effectuate a transfer of the Unduly Narrow issue to the CHS Unduly Narrow CIRP group, Case No. 26-2711GC or the issue may be dismissed from this case.

Board Members Participating:
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.
Clayton J. Nix, Esq.

FOR THE BOARD:



Clayton J. Nix, Esq.
Board Member

cc: Wilson C. Leong, Federal Specialized Services
Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-H)

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RE: Transfer Denial of Unduly Narrow Entitlement issue to SSI Percentage CIRP 22-1031GC-REINSTATEMENT
SSM Health St. Anthony Hospital-Midwest
Provider Number: 37-0094
Appealed Period: FYE 06/30/2019
PRRB Case Number: 23-0328

Dear Mr. Ravindran and Mr. Lamprecht:

On June 9, 2023, Community Health Systems, Inc. ("CHS") requested the transfer of an issue categorized as "DSH/SSI-Unduly Narrow Definition of SSI Entitlement" ("Unduly Narrow"/Issue #2) from the subject individual appeal for AllianceHealth Midwest (Prov. No. 37-0094) to the "CHS CY 2019 DSH SSI Percentage CIRP Group," Case No. 22-1031GC. Based on the Group Issue statement, the providers in the group are appealing the SSI Systemic Errors issue as discussed in Baystate Med. Ctr. v. Leavitt case ("Baystate").

BOARD DETERMINATION:

42 C.F.R. § 405.1837(b)(i) requires that two or more providers under common ownership or control appealing a COMMON issue for cost reports ending in the same calendar year must bring the appeal in the group format. (Emphasis added). For purposes of the transfer of the Provider's “Unduly Narrow” issue (#2) to the “CHS 2019 DSH SSI Percentage CIRP Group”- Case No. 22-1031GC, the Board finds that the Provider appealed a distinctly different issue in its individual appeal than the issue under appeal in the group case. The Unduly Narrow issue relates to the exclusion of unpaid SSI days from the Medicare Fraction numerator. The Provider's issue statement for this issue discusses the definition/interpretation of the word "entitled," and cites to the Supreme Court’s Empire Health Found. v Becerra, 142 S. Ct. 2354 (2022) ("Empire case"). Conversely the SSI Percentage group issue in Case No. 22-1031GC relates to the SSI Accuracy/Baystate issue, in that it clearly addresses the SSI data matching process and the potential errors in that process.

Because the Unduly Narrow issue which is related to the Empire decision (regarding entitlement to paid and unpaid Part A days) is not the same issue described in the SSI Percentage group which is related to the Baystate issue, the Board DENIES the transfer of Issue #2 from Case No. 23-0328 to Case No. 22-1031GC. Case No. 23-0328 is being reinstated to pursue the Unduly Narrow issue.

The Board notes that, on June 15, 2026, QRS filed a "CHS CY 2019 SSI Unduly Narrow Definition of SSI

Entitlement CIRP CIRP Group" under Case No. 26-2711GC which was later expanded to include CY 2018. Because a CIRP provider is required to pursue a common issue with related providers in a group, within 15 days of this notice, the Provider must effectuate a transfer of the Unduly Narrow issue to the CHS Unduly Narrow CIRP group, Case No. 26-2711GC or the issue may be dismissed from this case.

Board Members Participating:
Kevin D. Smith, CPA
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FOR THE BOARD:



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DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Notice of Dismissal***
Baylor University Medical Center, Prov. No. 45-0021, FYE 06/30/2020
Case No. 24-1905

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 24-1905. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 24-1905*

On **December 28, 2023**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2020.

On **June 13, 2024**, Quality Reimbursement Services, Inc. ("QRS") filed an appeal on behalf of the Provider which included six issues:

1. SSI - Provider Specific[1]
2. SSI Unduly Narrow Definition of SSI Entitlement[2]
3. Medicaid Eligible Days
4. SSI MCD Pt C[3]
5. Improper Ruling – SSI Medicare Fraction Dual Eligible Days[4]
6. Improper Ruling – Medicaid Fraction Dual Eligible Days[5]

The Provider is commonly owned/controlled by Baylor Scott & White Health (hereinafter "BS&W") and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1).

[1] On December 15, 2025, this issue was withdrawn.
[2] On January 31, 2025, this issue was transferred to Case No. 24-1926GC.
[3] On January 31, 2025, this issue was transferred to Case No. 24-1930GC.
[4] On January 31, 2025, this issue was transferred to Case No. 24-1928GC.
[5] On January 31, 2025, this issue was transferred to Case No. 24-1929GC.

On **June 13, 2024**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter* "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[6]

On **February 7, 2025**, the Provider timely filed its PPP and the Medicare Contractor ("MAC") filed its PPP on **May 23, 2025**.

On **November 25, 2025**, the MAC filed a jurisdiction challenge over the SSI Provider Specific & Medicaid Eligible Days issues. (SSI Provider Specific issue was subsequently withdrawn).

On **December 12, 2025,** the Provider filed a "Redacted Medicaid Eligible Days Listing" in OH CDMS.

On **December 13, 2025,** the Provider timely responded to the MAC's jurisdictional challenge.

Description of Issue 3 in the Appeal Request

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations. The Provider describes Issue 3 as:

> **Statement of Issue**
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.

[6] (Emphasis added.)

> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[7]

On February 7, 2025, the Provider filed its PPP in which it indicated that it would be sending the eligibility listing under separate cover.[8] The position paper did not identify how many Medicaid eligible days remained in dispute in this case. The following is the Provider's ***complete*** position on Issue 3 set forth therein:

> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106 (b) (4) of the Secretary's Regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v Shalala*, 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp. 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. §

[7] Appeal Request at Issue 3.
[8] Provider's PPP at 10.

> 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, including Section 1115 waiver days, the Provider contends that the total number of days reflected in its 2018 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.
>
> With respect to section 1115 waiver days, the courts have firmly rejected CMS's interpretation of its regulations, holding instead that the plain language of the statute and the regulations require inclusion in the Medicaid Fraction of the days belonging to individuals who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool. *See Forrest General Hospital*, 926 F.3d 221 (5th Cir. 2019); *HealthAlliance Hospitals, Inc. v. Azar*, 346 F. Supp. 3d 43(D.D.C. 2018); *Bethesda Health Inc., v. Azar*, 389 F. Supp. 3d 32, (D.D.C. 2019), *aff'd*, 980 F.3d 121 (D.C. Cir. 2020). CMS has acquiesced in *Bethesda* and is now following the statute and the plain meaning of its own regulations (which regulations represent the official policy of CMS all along). *See* CMS Manual Instructions System, Change Request 12669, Transmittal No. 11912 (March 163, 2023) ("Transmittal 11912"), attached as Exhibit P-4.[9]

MAC's Contentions- Issue 3 – DSH – Medicaid Eligible Days

The MAC contends that the Provider failed to properly develop its arguments within its PPP in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25. The MAC argues the Provider has not submitted an auditable list of Medicaid Eligible days, nor did it explain why it could not produce the documents. Therefore, the MAC considers the issue to have been abandoned and requests the Board dismiss the issue.

[9] Provider's PPP at 9-10.

Additionally, the MAC contends the Provider is attempting to improperly and untimely add the Section 1115 Waiver days issue. The Section 1115 Waiver days were not part of the initial appeal and were not mentioned until the PPP.

Provider's Jurisdictional Response

QRS filed a timely response to the MAC's jurisdiction challenge but only addressed the challenge over the Section 1115 waiver days sub-issue. QRS argued that:

1. Based on the phrasing of the issue statement, the Provider timely appealed the Medicaid Eligible Days issue. The statement included the following language:

   > The MAC, contrary to the regulation, failed to include all Medicaid eligible days, *including but not limited to* Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation. (Emphasis added.)

   According to QRS, "[b]y definition, section 1115 waiver days are Medicaid eligible days. See 42 C.F.R. § 412.106(b)(4)(i) and (ii)."[10]

2. Regarding the MAC's argument that the Provider abandoned the issue, QRS contends the MAC is required to accept and audit the Provider's section 1115 waiver days per CMS instruction. QRS asserts that it submitted a redacted listing (via upload to OH CDMS portal) and submitted an unredacted version to the MAC on December 15, 2025.[11]

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby ***dismisses*** the Provider's sole remaining issue.

A. DSH Payment – Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider's issue statement for Issue 3 is stated, *supra*.

[10] Jurisdictional Response at 1.
[11] Jurisdictional Response at 3-4.

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days that affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii), which places the burden of production on the provider states in pertinent part:

> The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

With regard to the filing of an individual appeal, Board Rule 7 - Support for Appealed Final Determination, Availability of Issue-Related Information and Basis for Dissatisfaction (Dec. 2023) states:

> The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal consisten with 42 C.F.R. 405.1835(b) or (d) as applicable. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a**

> **timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[12]

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Preliminary position paper requirements are set forth in Board Rule 25 (Dec. 2023). The Rule requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

Rule 25 - Preliminary Position Papers[13]

> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the following sub-sections.

25.1.1 The Provider's Position Paper

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
D. Provide a conclusion applying the material facts to the controlling authorities.

[12] (Bold emphasis added.)
[13] (Underline emphasis added to these excerpts and all other emphasis in original.)

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents
If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to the Board

Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's ***own motion***:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned;
- upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868);
- if the Board is unable to contact the provider or representative at the last known address; or
- upon failure to appear for a scheduled hearing.

Relative to a Medicaid Eligible Days determination, it is well-established that adequate data to prove eligibility for each Medicaid patient day claimed is a complete and accurate (i.e., auditable) Medicaid eligible days listing, which upon timely submission by a provider, a MAC can examine to make applicable adjustments.

This appeal was initiated on June 13, 2024 (more than 2 years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expect to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Provider's PPP indicated that it would be sending the eligibility listing under separate cover.[14]

On December 12, 2025, the Provider submitted a "Redacted Medicaid Eligible Days Listing Submission." The 2-page listing showed roughly 216 "Additional ME Days" and included the caveat that the "Listing [is] pending finalization upon receipt of State eligibility data." The Provider's filing did not explain why the listing was being submitted at that late date or why it was not final despite having been submitted more than six years after the fiscal year at issue had closed. Regardless, this filing was almost nineteen months past the deadline for including it with its PPP since that deadline was February 7, 2025.

The Board concurs with the MAC - that the Provider is required to identify *the material facts* (*i.e.*, the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(4)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board also finds that the Provider failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

Further, the Board rejects the Provider's attempts to include the eligible days listing filed on December 12, 2025 because:

[14] Provider's PPP at 10.

1. The upload was filed more than nineteen months *after the deadline* for the exhibits to be included with the PPP filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)).

2. The uploaded exhibit fails to explain the following critical information: (a) *why* it was being filed so late (*i.e*., upon what basis or authority should the Board accept the late filing); and (b) *why* the listing was not previously available, *in whole or in part* (*i.e*., it is not clear why the Provider failed to identify a single day at issue until almost 18 months after this appeal was filed and more than six years after the fiscal year at issue had closed).

3. Neither the Board Rules, nor the June 13, 2024 Case Acknowledgment and Critical Due Dates notice, permit the Provider to file a "Supplement" to its PPP.

4. Given that the *material* facts (*e.g*., the days at issue) and all available exhibits were required to be part of the PPP filing, if the Board were to accept the Redacted Listing Submission as a "Supplement" to the PPP, it would need to be either be a *refinement* of its PPP or a supplement of documents that were identified in the PPP as being unavailable consistent with Board Rule 25.2.2. However, neither the appeal request, nor the PPP, identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the uploaded listing cannot be considered a refinement of the position paper since no specific days or listing were included with the PPP.[15]

5. Finally, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[16] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the PPP filing (much less provide the § 412.106(b)(4)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

B. Section 1115 Waiver Days

The Board also concurs with the MAC that the Section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. While the Provider appealed Medicaid Eligible days, this issue is separate and distinct from the Section 1115 Waiver days.

The appeal was filed with the Board in June 2024 and the regulations required the following:

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[15] *See, e.g.,* Board Rule 27.3 (Dec. 2023) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."
[16] (Emphasis added.)

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[17]

Board Rule 7.2.1 (Dec. 2023) elaborated on this regulatory requirement, instructing providers:

> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
> - the adjustment, including the adjustment number,
> - the controlling authority,
> - why the adjustment is incorrect,
> - how the payment should be determined differently,
> - the reimbursement effect, and
> - the basis for jurisdiction before the [Board].

Board Rule 8 (Dec. 2023) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[18]

[17] 42 C.F.R. § 405.1835(b).
[18] (Bold and italic emphasis added).

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[19]

42 C.F.R. § 405.1835(e) provides in relevant part:

> (e) Adding issues to the hearing request. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
> . . .
> (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

In practice, this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination (*The time-period for adding issues to this case elapsed on August 29, 2024*). However, there is no evidence in the record to indicate the Provider properly or timely added the Section 1115 Waiver days issue to the case. The first mention of the issue was in the PPP filed on February 7, 2025, which was more than five months beyond the deadline to add an issue.

In this regard, the Board notes that Section 1115 Waiver days are not traditional Medicaid Eligible days and, indeed, were only incorporated into the DSH calculation effective January 20, 2000.[20] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying Section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a Section 1115 Waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) (2019) states in pertinent part:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for

[19] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[20] 65 FR 47054, 47087 (Aug. 1, 2000).

> inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.**
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for **each** Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Because the Provider did not raise the Section 1115 Waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The Medicaid Eligible days issue as stated in the original appeal request cannot be construed to include Section 1115 Waiver days. Additionally, there is no indication that any Section 1115 Waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

Regardless, even if the Provider had included in its appeal request (***which it did not***), the Provider failed to properly develop the issue in its PPP filing as it does not identify the specific 1115 Waiver day program(s) at issue). In addition, the PPP does not discuss whether or not the Section 1115 Waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the PPP is perfunctory in that it only makes cursory conclusions.[21] Again, the Provider failed to so develop its PPP, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 23 (Nov. 2021).

As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this

[21] For example, QRS cites to *Forrest General Hosp.*, 926 F.3d 221 (5th Cir. 2019) for the proposition that "the plain language of the statute and regulations require inclusion in the Medicaid Fraction of the days belong to individual who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool." However, QRS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is QRS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? QRS fails to brief the merits of its claims and fails to establish the Board's jurisdiction over the § 1115 waiver day issue as required by 42 C.F.R. § 405.1853(b)(2). Indeed, the quoted sentence is the only time the PPP references "uncompensated care pool."

paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* Section 1115 Waiver days sub-issue.

The Board's finding that neither the appeal request nor the PPP met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[22] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[23] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[24] The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[25] Here, the Board makes the same finding based on similar *overly generalized language.*

* * * * *

Based on the foregoing, the Board dismisses the last remaining issue in this case – Medicaid Eligible days (Issue #3) including Section 1115 Waiver days. As no issues remain, the Board hereby closes Case No. 24-1905 and removes it from the Board's docket.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.
Clayton J. Nix. Esq.

For the Board:

9/17/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-H)
Wilson Leong, FSS

[22] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[23] *Id*. at *11.
[24] *Id.*
[25] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
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RE: ***Notice of Dismissal***
The Nebraska Medical Center (28-0013), FYE 06/30/2018, Case No. 23-0525

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-0525. Set forth below is the decision of the Board to dismiss the two remaining issues in this appeal: the SSI Provider Specific and Medicaid Eligible Days issues.

Background

A. *Procedural History for Case No. 23-0525*

On **July 20, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2018.

On **January 13, 2023**, Quality Reimbursement Services, Inc. ("QRS") filed the Provider's appeal request. The request included two (2) issues:

1. DSH SSI Percentage (Provider Specific)
2. DSH Medicaid Eligible Days

The Provider is commonly owned by Nebraska Medicine so it is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1).

On **January 17, 2023**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter* "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must***

> *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 25.[1]

On **September 6, 2023**, QRS timely filed the Provider's PPP.

On **December 12, 2023**, the Medicare Contractor ("MAC") filed a jurisdictional challenge over the two issues in the appeal.

On **December 22, 2023**, the MAC timely filed its PPP.

On **February 10, 2026**, the Board issued a Notice of Hearing scheduling the case for a hearing date on **September 21, 2026**.

On **July 17, 2026**, the MAC filed a final PP.[2]

B. Description of Issue 1 in the Appeal Request

In its Individual Appeal Request, the Provider summarizes its DSH SSI Provider Specific issue as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e.

[1] (Emphasis added).
[2] The Provider did not file an optional final PP by the June 23, 2026 deadline.

> Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[3]

On September 6, 2023, the Board received the Provider's PPP in Case No. 23-0525. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of *Advocate Christ Medical Center, et al, v Xavier Becerra* (Appellants' reply brief included as Exhibit P-3).[4]

The amount in controversy listed for the SSI Percentage Provider Specific (Issue 1) is $217,259.

Description of Issue 2 in the Individual Appeal Request

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations. The Provider describes Issue 2 as:

> **Statement of Issue**

[3] Issue Statement at 1.
[4] Provider's PPP at 7-8.

> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[5]

The amount in controversy listed for the Medicaid Eligible Days issue (Issue 2) is $868,891.

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[6] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[7]

In addition, for the first time, the Provider mentions Section 1115 Waiver days:

> Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).

---

[5] Issue Statement at 2.
[6] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[7] Provider's PPP at 8-9.

> Based on the Listing of Medicaid Eligible days being sent under separate cover a redacted copy is attached), the Provider contends that the total number of days reflected in its 2018 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[8]

MAC's Contentions - Issue 1 –SSI Provider Specific

In its Jurisdictional Challenge, the MAC argues that the Board lacks jurisdiction over the DSH – SSI Provider Specific issue which involves three components: 1) SSI data accuracy; 2) SSI realignment and 3) individuals eligible for SSI but did not receive SSI payment. The MAC argues the provider abandoned the data accuracy and realignment components as it did not fully brief these issues in its PPP. The Provider failed to include all supporting exhibits to document the merits of its argument as required in 42 C.F.R. § 405.1853(b)(2) and Rule 25. In addition, the MAC maintains that there was no final determination over the SSI realignment so the appeal of this aspect of the issue is premature. With regard to the data match and entitlement components, the MAC contends the Provider is already pursuing this issue in Case No. 23-0316G ("QRS CY 2018 DSH SSI Unduly Narrow Definition of SSI Entitlement Group") to which it was directly added on January 13, 2023. Therefore, this issue would be prohibited per Board Rule 4.6.1 as it would be considered duplicative.[9]

MAC's Contentions - Issue 2 – Medicaid Eligible/Section 1115 Waiver Days

The MAC also argues that the Provider abandoned the Medicaid Eligible Days issue when it failed to properly develop its arguments within the PPP in accordance with 42 C.F.R. § 405.1853 and Board Rule 25. Additionally, the Provider failed to provide a list of additional Medicaid eligible days or any other supporting documents and did not provide an explanation for why it could not produce those documents.

Finally, the MAC contends the Provider is attempting to add the Section 1115 Waiver days issue improperly and untimely. The Section 1115 Waiver days were not part of the initial appeal, and were not even mentioned until the PPP submission, which was beyond the deadline to add issues.[10]

Provider's Jurisdictional Response

Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional

[8] Provider's PPP at 8-9.
[9] MAC's Jurisdictional Challenge at 2.
[10] *Id* at 10.

determination with the information contained in the record."[11] In this case, the Provider failed to file a response and the time for doing so elapsed as the deadline was January 11, 2024 (30 days after the December 12, 2023 filing).

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby ***dismisses*** the Provider's SSI Provider Specific and Medicaid Eligible Days issues.

A. SSI Provider Specific

The Provider's argument related to the data match component of the SSI Provider Specific issue concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[12] Per the appeal request, the Provider's legal basis for its DSH SSI Provider Specific issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[13] In the issue statement filed with the appeal request, the Provider argued, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[14]

The Board has previously noted that CMS' interpretation of the SSI percentage regulation is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations, and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[15] Accordingly, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced.

To this end, the Board also reviewed the Provider's PPP and finds that it failed to comply with Board Rule 25 (Nov. 2021) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Nov. 2021), the Board requires position papers "to be ***fully*** developed

[11] Board Rule v. 3.1 (Nov. 1, 2021).
[12] Issue Statement at 1.
[13] *Id.*
[14] *Id.*
[15] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of the any alleged "errors" and include *all* exhibits. For example, the Provider fails to explain how it can ascertain from State records, the entitlement of individuals, how that information is relevant, and whether such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2. Moreover, the Provider has failed to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents (Nov. 21, 2021)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[16]

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule

> "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") as explained on the following webpage:

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[16] (Italics and underline emphasis added.)

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[17]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on nor does it discuss claims to which it should have access. Accordingly, *based on the record before it*,[18] the Board finds that this aspect of the SSI Provider Specific issue in Case No. 23-0525 was not fully briefed in the PPP. Therefore, the ***Board dismisses this component of the SSI Provider Specific*** issue from Case No. 23-0525.

The Board also agrees with the MAC regarding the aspect of the issue related to "individuals that were eligible for SSI but did not receive an SSI payment." This Provider is already pursuing this issue as a participant in an optional group for the Unduly Narrow Definition of SSI Entitlement issue filed by QRS under Case No. 23-0316G. Therefore, the Board finds this component of the SSI Provider Specific issue to be duplicative - which is prohibited by Board Rule 4.6. Therefore, the ***Board dismisses this component of the SSI Provider Specific*** issue from the case.

Finally, the aspect of the SSI Provider Specific issue related to the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period, is also dismissed by the Board. Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ". Moreover, without this written request, the MAC cannot issue a final determination with which the Provider can be dissatisfied for Board appeal purposes. There is nothing in the record to indicate the MAC has made a final determination regarding an SSI Percentage realignment. In accordance with 42 C.F.R. § 405.1835(a)(1), the ***Board dismisses this aspect of the SSI Provider Specific*** issue from the appeal.

B. DSH Payment – Medicaid Eligible Days

1. *Medicaid Eligible Days*

The Provider did not include a finalized list of the specific additional Medicaid eligible days that are in dispute in this case in the initial appeal.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Nov. 2021) states:

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[17] Last modified July 31, 2026.
[18] Again, the Board notes that the Provider failed to timely respond to the Jurisdictional Challenge so the Board must make its determination based on the record before it.

> **No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[19]

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Board Rule 25 (Nov. 2021) requires the Provider to file its complete, *fully* developed PPP with all available documentation and gives the following instruction on the content of position papers:

> **Rule 25 Preliminary Position Papers**[20]

[19] (Bold emphasis added.)
[20] (Underline emphasis added to these excerpts and all other emphasis in original.)

COMMENTARY:

Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the following sub-sections.

25.1.1 The Provider's Position Paper

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
D. Provide a conclusion applying the material facts to the controlling authorities.

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

> If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.
>
> **25.2.3 List of Exhibits**
>
> Parties must attach a list of the exhibits exchanged with the position paper.
>
> **25.3 Filing Requirements to the Board**
>
> Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.
>
> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The January 17, 2023 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 2, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[21]

[21] (Emphasis added.)

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On September 6, 2023, the Provider filed its PPP paper in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.[22] The Provider's briefing of this issue in its PPP is stated *supra*.

In its December 12, 2023 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid Eligible days issue because the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable) with its appeal request or its PPP in violation of 42 CFR §405.1853 and Board Rule 25.3. Thus, the MAC asserts that the Provider has essentially abandoned the issue.[23]

The Board concurs with the MAC- that the Provider is required to identify *the material facts* (*i.e.*, the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R.

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[22] Provider's PPP at 9.

[23] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

§ 412.106(b)(4)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Provider failed to fully develop the merits of the Medicaid Eligible days issue because it failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue.

The Board recognizes that the Provider filed a ***redacted*** Eligible Days listing as an exhibit to its PPP, however:

1. An *auditable* version of the 5-page listing filed as Exhibit P-1 was not provided to the MAC;
2. The 5-page *redacted* ME days listing identified 1,556 'Additional ME Days'; however, no supporting documentation accompanied the exhibit.
3. The Provider did not include an explanation as to why the first time it was filing the ME days listing was more than 5 years after the fiscal year at issue had closed and almost 8 months after the appeal was filed.

The Board finds that the Provider has essentially abandoned the Medicaid Eligible days issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.

2. *Section 1115 Waiver Days*

In its jurisdiction challenge, the MAC also indicated the Provider was attempting to untimely and improperly add the issue of Section 1115 waiver days by including the issue in its PPP. The MAC pointed out that, although the waiver days issue is a component of the Medicaid Eligible days issue, it is considered a separate and distinct issue.

The Board concurs with the MAC and finds that the Section 1115 waiver days issue is not a part of this appeal as it was not included as a cost issue in the appeal, nor was it properly or timely added. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from Section 1115 waiver days.

The appeal was filed with the Board in January of 2023 and the regulations required the following:

> b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal,

> including an account of…
>
> (i) why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) how and why the provider believes Medicare payment must be determined differently for each disputed item…[24]

Board Rule 7.2.1 (Nov. 2021) elaborated on this regulatory requirement instructing providers:

> The following information and supporting document must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
>   - the adjustment, including the adjustment number,
>   - the controlling authority,
>   - why the adjustment is incorrect,
>   - how the payment should be determined differently,
>   - the reimbursement effect, and
>   - the basis for jurisdiction before the Board.[25]

Board Rule 8 (Nov. 2021) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these examples are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include…***Section 1115 waiver days (program/waiver specific)***[26]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[27]
42 C.F.R. § 405.1835(e) provides in relevant part:

> (c) *Adding issues to the hearing request*. After filing a hearing request… a provider may add specific Medicare payment issues to

[24] 42 C.F.R. § 405.1835(b).
[25] v. 3.1 (Nov. 2021).
[26] (Bold and italic emphasis added).
[27] *See* 73 Fed. Reg. 30190 (May 23, 2008).

> the original hearing request by submitting a written request to the Board, only if –
> . . .
>
> (2) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

In practice this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider properly or timely added the Section 1115 waiver days issue to the case.

In this regard, the Board notes that Section 1115 waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[28] Rather, they relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program ***and*** not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction.[20] In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) (2019) states in pertinent part:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching**

[28] 65 FR 47054, 47087 (Aug. 1, 2000).

> **payments through a waiver approved under section 1115 of the Social Security Act**.
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Because the Provider did not raise the Section 1115 waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The Medicaid eligible days issue as stated in the original appeal request cannot be construed to include Section 1115 waiver days. Additionally, there is no indication that any Section 1115 waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

Regardless, even if the Provider had included the Section 1115 waiver days issue in its appeal request (*which it did not*), the Provider failed to properly develop the issue in its PPP filing. The Provider's PPP does not identify the specific 1115 waiver day program(s) at issue) notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (2021). Pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* Section 1115 waiver days sub-issue.

The Board's finding that neither the appeal request nor the PPP met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[29] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[30] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[31] The Court found that this description of the issue was a violation of Board rules and a proper basis for the Board to dismiss the appeal.[32] Here, the Board makes the same finding based on similar *overly generalized language*.

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[29] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[30] *Id*. at *11.
[31] *Id.*
[32] *Id.*

Based on the above, the Board finds that ***the appeal did not include the alleged Section 1115 waiver days sub-issue*** consistent with 42 C.F.R. §§ 405.1835(b)(2)-(3), 412.106(b)(4)(iii), and 405.1871(a)(3) and Board Rules 7.1, 8, 25, and 27.2.[33] In the alternative, the Board finds that, even if it had been included as part of the appeal, the issue was not properly developed in the PPP process.

* * * *

Based on the foregoing, the Board is ***dismissing the SSI Provider Specific and Medicaid Eligible Days/Section 1115 Waiver Days issues*** in this case. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.
Clayton J. Nix, Esq.

For the Board:

9/17/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Byron Lamprecht, WPS Government Health Admin. (J-5)
Wilson Leong, FSS

[33] If section 1115 waiver days were found to be part of the appeal request and had been properly briefed, the Board would still need to address an additional jurisdictional issue – review whether it had jurisdiction over the section 1115 waiver days. For example, the Board has found that when a class of days (*e.g.*, 1115 waiver days) is excluded due to choice, error, and/or advertence from the as-filed cost report, then that class of days is an unclaimed cost for which the Board would lack jurisdiction under 42 U.S.C. § 1395oo(a). *See, e.g.,* PRRB Jurisdictional Decision, Case Nos. 06-1851, 061852 (Nov. 17, 2017) (dismissing the class of adolescent psychiatric days from the appeal because no days were claimed with the as-filed cost report due to choice, error and/or inadvertence and, as such, the practical impediment standard or futility concept in the *Norwalk* and *Danbury* Board decisions is not applicable).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Murry McGowan
Tenet Healthcare Corporation
14201 Dallas Parkway
Dallas, TX 75254

RE: ***Notice of Dismissals***
Case Numbers: 23-0685GC *et al* (7 Cases, *see* **Appendix A**)
Tenet Healthcare S-10 Data for DSH Uncompensated Care Payment CIRP Groups

Dear Mr. McGowan,

The Provider Reimbursement Review Board ("Board") has reviewed the documents in the above-referenced group appeals. The decision of the Board to dismiss the seven (7) cases listed in **Appendix A** is set forth below.

Pertinent Facts:

The Providers in these appeals are all part of the same parent organization, Tenet Healthcare Corporation. Each participant in each group case is appealing from an original Notice of Program Reimbursement ("NPR").

These appeals are challenging the use of Worksheet S-10 data "for any purpose that could have an adverse payment impact for this or any future cost reporting period" as well as "all potential adverse payment impacts that may occur"[1] from its use. They further argue:

> The potential adverse payment impacts associated with these issues necessarily are unknown to the Provider at this time. The adverse impacts may arise under rules that have not yet been adopted by CMS, may be unrelated to payments for the cost reporting period covered by this cost report, or may be due to CMS' failure to: (1) properly calculate the cost of subsection (d) hospitals for treating the *uninsured* or; (2) use *appropriate* data for Factor Three, as required by Section 3133 of the Patient Protection and Affordable Care Act (Public Law 111–148).[2]

[1] *E.g*. Case No. 23-0685GC, CIRP Group Issue Statement (Jan. 27, 2023).
[2] *Id.* (Italics emphasis in original).

The Providers are attempting to preserve their right to appeal "any adverse payment impact for this and any other cost reporting period to the extent that it stems from inappropriate, incomplete, inconsistent or inadequate data reported on Worksheet S-10."[3]

Relevant Law and Analysis:

A. Bar on Administrative Review

The Board does not generally have jurisdiction over Uncompensated Care DSH payment issues because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review of certain aspects of the UCC payment calculation. Based on these provisions, judicial and administrative review is precluded under 42 U.S.C. §§ 1395ff and 1395oo for:

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[4]
>
> (B) Any period selected by the Secretary for such purposes.

B. Interpretation of Bar on Administrative Review

1. Tampa General v. Sec'y of HHS

In *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs*. ("*Tampa General*"),[5] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[6] that there is no judicial or administrative review of uncompensated care DSH payments. In that case, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit found that there was specific language in the statute that precluded administrative or judicial review of the provider's claims because in challenging the use of the

---

[3] *Id.*
[4] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.
[5] 830 F.3d 515 (D.C. Cir. 2016).
[6] 89 F. Supp. 3d 121 (D.D.C. 2015).

March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit went on to hold that "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[7] The D.C Circuit also rejected the provider's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[8]

The D.C. Circuit went on to address the provider's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[9]

2. DCH Regional Med. Ctr. v. Azar

The D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar* ("*DCH v. Azar*").[10] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment. Indeed, they stated that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[11] It continued that allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." Recalling that it had held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves, the D.C. Circuit found the same relationship existed with regard to the methodology used to generate the estimates.[12]

3. Yale New Haven Hosp. v. Azar

The District Court for the District of Connecticut subsequently considered the bar on review of UCC DSH payments in *Yale New Haven Hosp. v. Azar*.[13] There, the Court dismissed all of the providers' counts in their federal complaint except one.[14] Those that clearly sought to "undo the Secretary's estimate of its uncompensated care by recasting its challenge to that estimate as an

[7] 830 F.3d 515, 517.
[8] *Id.* at 519.
[9] *Id.* at 521-22.
[10] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[11] *Id.* at 506.
[12] *Id.* at 507.
[13] 409 F.Supp.3d 3 (D. Conn. 2019).
[14] *Id.* at 18-19.

attack on the underlying methodology" were dismissed.[15] The remaining count, the court held, did "not challenge the Secretary's estimate of [the provider's] DSH payment, any of the underlying data, or the Secretary's choice of such data. Instead, it [was] a challenge to the procedure by which the Secretary established the" issue under appeal.[16] The court noted that it was a close call, but there was no bar on review of "the promulgation of the Secretary's rules and policies, separate from the substance of any such rules or policies or the determination of its estimates based on the substance of those rules or policies."[17] On appeal, the Second Circuit affirmed the decision, concluding "that the plain and ordinary meaning of section 1395ww(r)(3)'s text bars *any* challenge to an 'estimate of the Secretary" – whether cast in substantive or procedural terms[.]"[18]

4. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[19] the D.C. District Court considered a similar challenge and held that administrative review was precluded. In *Scranton*, the providers were challenging how the Secretary determined the amount of uncompensated care that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.[20] For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and SSI patient days from 2012 cost reports, unless that cost report was unavailable or was for a period less than twelve months. In that scenario, the Secretary would calculate the FY 2015 DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.[21] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a subsequent cost report that was a full twelve months.[22] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[23]

In *Scranton*, the providers argued that, unlike the providers in *Tampa General* and *DCH v. Azar* who were specifically attacking the methodology and policies adopted by the Secretary, they

[15] *Id.* at 14 (quoting *DCH v. Azar* at 508).
[16] *Id.*
[17] *Id.* at 15. The District Court for Connecticut later ruled that the UCC DSH payment rule at issue in that case (the Merger Hospital Policy), which is distinct from the Worksheet S-10 Audit policy at issue in this case, had not undergone sufficient notice and comment procedures. 457 F.Supp.3d 93, 111 (D. Conn. 2020). The court balanced different considerations in coming up with a remedy and ultimately remanded the case to the Secretary without vacatur of the rule. *Id.* at 112.
[18] *Yale New Haven Hosp. v. Becerra*, 56 F.4th 9, 13 (2nd Cir. 2022).
[19] 514 F. Supp. 249 (D.D.C. 2021).
[20] *Id.* at 255-56.
[21] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[22] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.
[23] *Id.*

were simply trying to enforce those policies. The D.C. District Court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH v. Azar*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[24]

Finally, and perhaps most importantly, the D.C. District Court found that any allegations that the Secretary departed from her own policy and/or acted *ultra vires* did not alter its decision. The D.C. District Court found that, in the context of the bar on review of the Secretary's estimates used and periods chosen for calculating the factors in the UCC payment methodology, "saying that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[25] While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such review is precluded by statute, the criteria in *Scranton* were not met.[26] For review to be available in these circumstances, the following criteria must satisfied:

> (i) the statutory preclusion of review is implied rather than express; (ii) there is no alternative procedure for review of the statutory claim; and (iii) the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.[27]

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which requires a violation of a clear statutory command.[28] The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

5. Ascension Borgess Hospital v. Becerra

Even more recently, the D.C. Circuit revisited, once again, the judicial and administrative bar on review of uncompensated care DSH payments again in *Ascension Borgess Hospital v. Becerra* ("*Ascension Borgess*").[29] In *Ascension Borgess*, the providers sought "an order declaring the Worksheet S-10 audit protocol unlawful, vacating the payments based on the Worksheet S-10

[24] *Id.* at 262-64.
[25] *Id.* at 265.
[26] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[27] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[28] *Id.* at 264-65 (quoting *DCH v. Azar*, 925 F.3d at 509).
[29] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).

audit, requiring the Secretary to recalculate those payments, and setting aside the [Board] decisions refusing to exercise jurisdiction over their appeals."[30] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the providers claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar* where it "repeatedly applied a "functional approach" focused on whether the challenged action was " 'inextricably intertwined' with the unreviewable estimate itself" and eschewing "categorical distinction between inputs and outputs."[31] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[32] noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in evaluating the merits of plaintiffs' claims—i.e., that the Worksheet S-10 audit protocol establishes or changes a substantive legal standard within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision***."[33]

6. Ascension Providence v. Becerra

Finally, in *Ascension Providence v. Becerra*,[34] certain hospitals appealed to the Board "to challenge the procedurally unlawful policy CMS implemented that used Worksheet S-10 adjustments to and/or disallowances of their Uncompensated Care (UC) Costs derived from audits of Fiscal Year (FY) 2017 S-10 Worksheets of only a certain percentage of Disproportionate Share (DSH) Hospitals to establish the Federal Fiscal Year (FFY) 2021 US Payments in the Medicare Inpatient Prospective Payment System (IPPS) Final Rule"[35] The court narrowed the issue to a "challenge to the audit protocol used for auditing the FY 2017 Worksheet S-10 data that was used in calculating Factor 3 for FY 2021."[36]

The court noted that audited data is an estimate for the purposes of determining the [uncompensated care] factors, which is precluded from review. It also reiterated that challenging the audit protocol themselves would be an effort to declare the resulting calculations invalid. "Thus, the review of the audit protocols is functionally a review of the estimate, which is not allowed."[37] This was another example in which a court rejected a "procedural challenge" to some aspect of the uncompensated care calculations. It acknowledged that the "procedural" challenge was really just an attempt to change the reimbursement impact on the hospitals' DSH payments, which is a precluded challenge to the Secretary's estimate.[38]

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[30] *Id*. at *127.
[31] *Id.* at *134.
[32] 139 S. Ct. 1804 (2019).
[33] *Ascension* at *132 (bold italics emphasis added).
[34] 2023 WL 2042176, (D.N.D. Ind., Feb. 16, 2023).
[35] *Id.* at *5.
[36] *Id.*
[37] *Id.* at *6.
[38] *Id.* at *8.

Board Decision:

Most of the Issue Statements in these cases focus on vague, unknown damages and do not specify what payment is incorrect or how it should be paid differently. They even go so far as to say that the damages might arise from rules that are not even in existence yet.[39] Each participant has been issued an NPR, and should be able to determine what, if any, payments were impacted by S-10 data for these specific final determinations. The Board finds that the general grievances listed and preemptive challenges to rules not yet established do not comply with the content requirements for a Board hearing found at 42 C.F.R. § 405.1835(b)(2):

> (2)For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final contractor or Secretary determination under appeal, including an account of all of the following:
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.
>
> (iii) If the provider self-disallows a specific item (as specified in § 413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.

The only specific grievances listed are allegations that CMS failed "to (1) properly calculate the cost of subsection (d) hospitals for treating the *uninsured,* or (2) use *appropriate* data for Factor Three."[40] The underlying data, as well as the methodologies for estimating or gathering that data, have been found to be precluded from administrative or judicial review in the numerous court opinions outlined above since they are "inextricably intertwined" with the actual estimates.

Accordingly, the Board dismisses the seven (7) cases listed in **Appendix A** and removes them from the Board's docket. The Board notes that its ruling is consistent with the D.C. Circuit's decision in *Tampa General*, *DCH v. Azar*, and *Ascension Borgess* and that these decisions are controlling precedent for the interpretation of 42 U.S.C. § 1395ww(r)(3) because the Providers could bring suit in the D.C. Circuit.[41] Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

---

[39] *E.g.*, Case No. 23-0685GC, CIRP Group Issue Statement.
[40] *Id.* (Italics emphasis in original).
[41] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v.*

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.
Clayton J. Nix, Esq.

For the Board:

9/18/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: KEVIN D. SMITH -A

cc: Wilson C. Leong, Esq., Federal Specialized Services
Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-H)

BlueCross BlueShield Ass'n, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

Appendix A

Case 23-0685GC	*Tenet Healthcare CY 2019 Worksheet S-10 Data for DSH Uncompensated Care Payment CIRP Group*
Case 23-0961GC	*Tenet Healthcare CY 2018 S-10 Data for DSH Uncompensated Care Payment CIRP Group CIRP Group*
Case 23-1536GC	*Tenet Healthcare CY 2020 S-10 data for Uncompensated Care CIRP Group*
Case 24-2213GC	*Tenet Healthcare CY 2021 S-10 Data Fraction Uncompensated Care CIRP Group*
Case 25-1458GC	*Tenet Healthcare CY 2022 S-10 Data Fraction Uncompensated Care CIRP Group*
Case 25-6036GC	*Tenet Healthcare CY 2023 S-10 Data Fraction Uncompensated Care CIRP Group*
Case 26-2795GC	*Tenet Healthcare CY 2024 S-10 Data Fraction Uncompensated Care CIRP Group*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244
410-786-2671

September 18, 2026

Dena Pearson
Administrator
1st Texas Home Health
4004 Call Field Road
Wichita Falls, TX 76306

Dana Johnson
Lead Auditor
Palmetto GBA c/o Wellpoint Federal Solutions, Inc. (J-M)
ATTN: Cost Report Appeals
P.O. Box 7040
Indianapolis, IN 46207-7040

RE: Dismissal for Failure to Respond
1st Texas Home Health
Provider Number: 67-9027
Appealed Period: Period Ended 03/31/2024
PRRB Case Number: 25-4324

Dear Ms. Pearson and Ms. Johnson:

Pursuant to 42 C.F.R. § 405.1868, the Provider Reimbursement Review Board ("Board") has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provision of section 1878 of the Act and of the regulations. The Board's powers include the authority to take appropriate actions in response to the failure of a party to comply with Board rules and orders. Specifically, if a Provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may dismiss the appeal with prejudice.

On May 6, 2026, a Notice of Hearing was issued and established critical due dates and set forth a live hearing date for September 21, 2026.

Since this date, as outlined in the Board's September 2, 2026 and September 15, 2026 letters, the Board takes note that the Provider has failed on multiple attempts to properly or timely submit information to the Board.

The Board's September 15, 2026 letter outlined requirements the Provider must comply with, and stated:

The Provider must file in OH CDMS by 5 p.m. EST on Thursday, September 17th. In accordance with 42 C.F.R. § 405.1868, failure of the Provider to respond by the deadline will result in dismissal of the case. No further leniency will be granted.

Board Rule 41.2 states:

The Board may dismiss a case or an issue on its own motion:
• if it has a reasonable basis to believe that the issues have been fully settled or abandoned;
• upon failure of the provider or group to comply with Board procedures or filing deadlines (see 42 C.F.R. § 405.1868);
• if the Board is unable to contact the provider or representative at the last known address; or

• upon failure to appear for a scheduled hearing.

As the Provider has not responded to the Board's recent letter, the Board hereby dismisses this case.

Board Members Participating:
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.
Clayton J. Nix, Esq.

FOR THE BOARD:



Kevin D. Smith, CPA
PRRB Chair

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Blvd.
Mail Stop: B1-01-31
Baltimore, MD 21244
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Via Electronic Delivery

Nathan Summar, Vice President, Revenue Mgmnt
Community Health Systems, Inc.
4000 Meridian Boulevard
Franklin, TN 37067

RE: ***Notice of Dismissal***
Tennova Healthcare-Jefferson Memorial Hospital (Prov. No. 44-0056), FYE 09/30/2021
Case No. 25-4396

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 25-4396. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 25-4396*

On **November 20, 2024**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2021.

On **May 5, 2025**, the Board received the Provider's individual appeal request. The Appeal Request was filed by Community Health Systems, Inc. ("CHS") and included five (5) issues:

1. DSH Pymt/SSI % (Provider Specific)[1]
2. DSH Pymt - Medicaid Eligible Days
3. Medicare Managed Care Part C – SSI & Medicaid Fractions[2]
4. Improper Rulemaking – SSI Fraction Dual Eligible Days[3]
5. Improper Rulemaking – Medicaid Fraction Dual Eligible Days[4]

The Provider is commonly owned by CHS, so it is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1).

On **May 6, 2025**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers

[1] On December 22, 2025, this issue was withdrawn.
[2] On December 1, 2025, this issue was transferred to Case No. 24-1834GC.
[3] On December 1, 2025, this issue was transferred to Case No. 24-1835GC.
[4] On December 1, 2025, this issue was transferred to Case No. 24-1836GC.

(hereinafter "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[5]

On **December 29, 2025**, CHS filed the Provider's PPP.

On **January 6, 2026,** the MAC filed a copy of its request to the Provider for an Auditable Medicaid Eligible Days Listing.

On **March 19, 2026,** the MAC filed its PPP.

On **April 1, 2026**, the MAC filed a Jurisdictional Challenge.

MAC's Contentions- DSH – Medicaid Eligible Days

The MAC contends that the Provider abandoned the Medicaid Eligible Days issue when it failed to include a list of additional Medicaid eligible days it expected to be included with its appeal or is PPP. Therefore, the issue was abandoned when the PPP was not filed in accordance with Board Rule 25.3 and 42 CFR § 405.1853. Additionally, the Provider has failed to submit an unredacted, auditable list of additional Medicaid eligible days or any other supporting documents or explanation for why it cannot produce those documents.

The MAC also contends the Provider is attempting to untimely and improperly add the issue of Section 1115 waiver days via its PPP, filed on December 29, 2025. The MAC asserts that prior to the PPP, the Provider had not formally added the dispute to the appeal, nor had it otherwise raised the issue of Section 1115 waiver days.[6] Finally, the MAC argues that Section 1115 waiver days issue is one component of the DSH issue - and is a separate and distinct issue from Medicaid eligible days issue so it must be identified and appealed separately.[7]

Provider's Jurisdictional Response

Board Rule 44.4.3 requires that: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via

[5] (Emphasis added.)
[6] MAC Jurisdiction Challenge at 8.
[7] *Id.*at 9.

a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so elapsed on May 1, 2026.

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby ***dismisses*** the Provider's sole remaining issue.

A. DSH Payment – Medicaid Eligible Days

The Provider did not include a list of the specific additional Medicaid eligible days that are in dispute in the initial appeal.

With regard to the filing of an individual appeal, Board Rule 7 - Support for Appealed Final Determination, Availability of Issue-Related Information and Basis for Dissatisfaction (Dec. 2023) states:

> **No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a**

> **timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[8]

The regulations require the parties to fully brief the merits of each issue in their PP (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Board Rule 25 (Dec. 2023) requires the Provider to file its complete, *fully* developed PPP with all available documentation and gives the following instruction on the content of PPs:

Rule 25 - Preliminary Position Papers[9]

> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the following sub-sections.

25.1.1 The Provider's Position Paper

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
D. Provide a conclusion applying the material facts to the controlling authorities.

25.2 Position Paper Exhibits

---

[8] (Bold emphasis added.)
[9] (Underline emphasis added to these excerpts and all other emphasis in original.)

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to the Board

Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The May 6, 2025 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with the Medicaid Eligible Days issue, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[10]

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On December 29, 2025, the Provider filed its PPP in which it indicated that the eligibility listing was imminent by promising that the listing was being sent to the MAC under separate cover.[11] The Provider's complete briefing of this issue in its PPP is as follows:

[10] (Emphasis added.)
[11] Provider's PPP at 9.

Calculation of Medicaid Eligible Days

The Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.

The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).

The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:

> [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.

Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).

> Based on the Listing of Medicaid Eligible days being sent under separate cover to the MAC (redacted listing to follow), the Provider contends that the total number of days reflected in its 2019 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.
>
> With respect to section 1115 waiver days, the courts have firmly rejected CMS's interpretation of its regulations, holding instead that the plain language of the statute and the regulations require inclusion in the Medicaid Fraction of the days belonging to individuals who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool. *See Forrest General Hospital*, 926 F.3d 221 (5th Cir. 2019); *HealthAlliance Hospitals, Inc. v. Azar*, 346 F. Supp. 3d 43(D.D.C. 2018); *Bethesda Health Inc., v. Azar*, 389 F. Supp. 3d 32, (D.D.C. 2019), *aff'd,* 980 F.3d 121 (D.C. Cir. 2020). CMS has acquiesced in *Bethesda* and is now following the statute and the plain meaning of its own regulations (which regulations represent the official policy of CMS all along) and properly accounting for 1115 Waiver days as Medicaid Eligible days. *See* CMS Manual Instructions System, Change Request 12669, Transmittal No. 11912 (March 16, 2023) ("Transmittal 11912"), attached as Exhibit P-3.[12]

In its April 1, 2026 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid Eligible days issue because the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable) with its appeal request or its PPP in violation of 42 CFR §405.1853 and Board Rule 25.3. Thus, the MAC asserts that the Provider has essentially abandoned the issue.[13] In addition, the MAC indicated the Provider was attempting to untimely and improperly add the issue of Section 1115 waiver days by including the issue in its PPP. The MAC pointed out that, although the waiver days issue is a component of the Medicaid Eligible days issue, it is considered a separate and distinct issue.

The Board concurs with the MAC- that the Provider is required to identify *the material facts* (*i.e.*, the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(4)(iii). Specifically, the Board finds that the Provider has failed to satisfy the

[12] Provider's PP at 8-10.
[13] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

requirements of 42 C.F.R. § 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Provider failed to fully develop the merits of the Medicaid Eligible days issue because it failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue.

The Board recognizes that the Provider filed a redacted Eligible Days listing as an exhibit to its PPP, however:

1. An *auditable* version of the 5-page listing at Exhibit P-1 was not provided to the MAC;
2. The 5-page redacted listing shows roughly 703 "Additional ME Days" but includes the caveat "Listing pending finalization upon receipt of State eligibility data." There was no support accompanying the exhibit.
3. The Provider did not include an explanation as to why the first time it was filing the ME days listing was more than 4 years after the fiscal year at issue had closed and almost 8 months after the appeal was filed, nor did it explain why the listing was not yet final.

The Provider has essentially abandoned the Medicaid Eligible days issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.

B. Section 1115 Waiver Days

The Board also concurs with the MAC, that the Section 1115 waiver days issue is not a part of this appeal as it was not properly or timely added. While the Provider appealed Medicaid Eligible days, this issue is separate and distinct from the Section 1115 waiver days.

The appeal was filed with the Board in May of 2025 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]

> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[14]

Board Rule 7.2.1 (2023) elaborated on this regulatory requirement, instructing providers:

> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
> - the adjustment, including the adjustment number,
> - the controlling authority,
> - why the adjustment is incorrect,
> - how the payment should be determined differently,
> - the reimbursement effect, and
> - the basis for jurisdiction before the [Board].

Board Rule 8 (Dec. 2023) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[15]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[16]

42 C.F.R. § 405.1835(e) provides in relevant part:

> (e) Adding issues to the hearing request. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
> . . .
> (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

[14] 42 C.F.R. § 405.1835(b).
[15] (Bold and italic emphasis added).
[16] *See* 73 Fed. Reg. 30190 (May 23, 2008).

In practice, this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider properly or timely added the Section 1115 waiver days issue to the case.

In this regard, the Board notes that Section 1115 waiver days are not traditional Medicaid Eligible days and, indeed, were only incorporated into the DSH calculation effective January 20, 2000.[17] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 waiver days. Indeed, not every state Medicaid program has a qualifying Section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a Section 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) (2019) states in pertinent part:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.**
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for **each** Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

[17] 65 FR 47054, 47087 (Aug. 1, 2000).

Because the Provider did not raise the Section 1115 waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The Medicaid Eligible days issue as stated in the original appeal request cannot be construed to include Section 1115 waiver days. Additionally, there is no indication that any Section 1115 Waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

Regardless, even if the Provider had included in its appeal request (***which it did not***), the Provider failed to properly develop the issue in its PPP filing as it does not identify the specific 1115 waiver day program(s) at issue). In addition, the PPP does not discuss whether or not the Section 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the PPP is perfunctory in that it only makes cursory conclusions.[18] Again, the Provider failed to so develop its PPP, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 23 (Dec. 2023).

As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* Section 1115 waiver days sub-issue.

The Board's finding that neither the appeal request nor the PPP met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[19] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[20] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor

[18] For example, CHS cites to *Forrest General Hosp.*, 926 F.3d 221 (5th Cir. 2019) for the proposition that "the plain language of the statute and regulations require inclusion in the Medicaid Fraction of the days belong to individual who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool." However, CHS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is CHS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? CHS fails to brief the merits of its claims and fails to establish the Board's jurisdiction over the § 1115 waiver day issue as required by 42 C.F.R. § 405.1853(b)(2). Indeed, the quoted sentence is the only time the PPP references "uncompensated care pool."

[19] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

[20] *Id*. at *11.

how the fraction should have been calculated differently."[21] The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[22] Here, the Board makes the same finding based on similar *overly generalized language.*

* * * * *

Based on the foregoing, the Board dismisses the sole remaining issue in this case – Medicaid Eligible days (including Section 1115 waiver days.) As no issues remain, the Board hereby closes Case No. 25-4396 and removes it from the Board's docket.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.
Clayton J. Nix. Esq.

For the Board:

9/22/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Cecile Huggins, Palmetto GBA (J-J)
Wilson Leong, FSS

[21] *Id.*
[22] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran, President
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Board Decision – Dismissal of DSH Payment/SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues***
Springs Memorial Hospital (Prov. No. 42-0036), FYE 11/30/2018
Case No. 23-0650

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-0650. Set forth below is the background of the case and the Board's decision related to the issues challenging the SSI-Provider Specific and Medicaid Eligible Days issues.

Background:

A. *Procedural History for Case No. 23-0650*

On **August 16, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end November 30, 2018.

On **January 26, 2023**, Community Health Systems ("CHS") filed an appeal on behalf of the Provider. The Appeal Request included five (5) issues:

1. SSI - Provider Specific
2. SSI - Unduly Narrow Definition of SSI Entitlement[1]
3. Medicaid Eligible Days
4. Medicare Managed Care Part C - SSI & Medicaid Fractions[2]
5. Dual Eligible Days - SSI and Medicaid Fractions[3]

The Provider is commonly owned by CHS, so it is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1).

[1] On August 7, 2023, CHS transferred this issue to an SSI Systemic Errors CIRP Group, Case No. 21-1206GC. On August 7, 2026, the Board subsequently denied the transfer because it determined the issues were not the same. On August 12, 2026, QRS transferred the issue to a new Unduly Narrow CIRP group under Case No. 26-2711GC.
[2] On August 7, 2023, this issue was transferred to Case No. 20-2149GC.
[3] On August 7, 2023, this issue was transferred to Case No. 21-0066GC.

On **January 30, 2023**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates ("ACDD"), providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter* "PPP".) This Notice also gave the following instructions to the Provider regarding the content of its PPP:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[4]

On **September 21, 2023**, CHS filed the Provider's PPP.

On **November 16, 2023**, the Medicare Contractor ("MAC") filed a jurisdictional challenge.

On **January 12, 2024,** the MAC filed its PPP.

On **August 4, 2026**, the case was scheduled for a hearing on January 15, 2027.

On **August 11, 2026,** CHS filed a change in representation to Quality Reimbursement Services, Inc. ("QRS") which the Board acknowledged the same day.

B. Description of Issue 1 in the Appeal Request

In its Individual Appeal Request, the Provider summarizes its SSI Percentage (Provider Specific) issue as follows:

> The Provider contends that its'[sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that

[4] (Emphasis added.)

> CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator'. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[5]

On September 21, 2023, the Board received the Provider's PPP in Case No. 23-0650. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[6]

[5] Issue Statement at 1.
[6] Provider's PPP at 7-8.

The amount in controversy listed for both Issue 1 and Issue 2 in the Provider's individual appeal request is $24,823.

Description of Issue 3 in the Appeal Request

In its Individual Appeal Request, the Provider questions whether the MAC properly excluded Medicaid eligible days from the DSH calculation. The Statement of the Legal Basis is as follows:

> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 7, 8, 37, S-D
> Estimated Reimbursement Amount: $54,133 [7]

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[8] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[9]

The Provider then, for the first time in this appeal, states it is seeking reimbursement for section 1115 waiver days as a part of the Medicaid eligible day issue. Specifically, the Provider states:

> [M]edicaid eligible days (including section 1115 waiver days (where applicable), which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115

[7] Issue Statement at 3.
[8] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[9] Provider's PPP at 8.

waiver days).[10]

MAC's Contentions: Issue 1 – DSH SSI Provider Specific

In its jurisdictional challenge, the MAC argues that the Board lacks jurisdiction over the SSI-Provider Specific issue, which has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the sub-issue related to SSI should be dismissed because it is duplicative of the SSI issue under appeal in the CIRP group.[11] The component related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies. The MAC asserts the SSI data accuracy portion of the issue should be dismissed because the Provider did not file a complete PPP in accordance with 42 C.F.R. § 405.1853 and Board Rule 25.[12]

MAC's Contentions: Issue 3 – DSH Medicaid Eligible Days

The MAC also argues the Board lacks jurisdiction over the Medicaid Eligible Days issue. The MAC contends that the Provider failed to include a list of additional Medicaid eligible days they expect to be included with their appeal or their PPP, even though the Provider advised that it would send a listing of additional Medicaid eligible days under separate cover, and even after the MAC sent the Provider a request for the information.

The MAC also challenges the Provider's attempt to untimely add the Section 1115 Waiver Days issue by including it in the narrative of the PPP.[13] In addition, the MAC argues the Section 1115 Waiver Days is a separate and distinct issue.[14]

Provider's Jurisdictional Response

Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."[15] The Provider failed to file a timely response by the *December 16, 2023* deadline.

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is

[10] *Id.* at 8-9.
[11] The Unduly Narrow Definition of SSI Entitlement issue was ultimately transferred to Case No. 26-2711GC.
[12] MAC Jurisdiction Challenge at 2.
[13] *Id.* at 13.
[14] *Id.* at 15.
[15] Board Rule 44.4.3, v. 3.1 (Nov. 2021).

$10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby dismisses the Provider's Issue Nos. 1 and 3.

A. SSI Percentage (Provider Specific)

The analysis for Issue No. 1 has two relevant aspects to consider: (1) the Provider's disagreement with how the MAC computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

The aspect of Issue No. 1 related to the Provider's disagreement with how the MAC computed the SSI percentage because of CMS' policy of excluding patients that were entitled to SSI from the numerator of the Medicare fraction—is duplicative of the Unduly Narrow Definition of SSI Entitlement issue that is being pursued as Issue #2.

The SSI- Provider Specific issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[16] Per the appeal request, the Provider's legal basis for its SSI Percentage (Provider Specific) issue asserts that the MAC "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[17] The Provider argues that "its'[sic] SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[18] Finally, the Provider argues that CMS inconsistently interprets the term "entitled" as used in the statute because it requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. "CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment." These arguments are restated in Issue No. 2 where the Provider points to CMS' policy of applying different interpretations to the term "entitled."[19]

The Board finds that aspect of the issue related to the term "entitled" in Case No. 23-0650 is duplicative of the Unduly Narrow issue described at Issue No. 2, which was subsequently transferred to a CIRP group, Case No. 26-2711GC. Because the issue is duplicative, and

[16] Issue Statement at 1.
[17] *Id.*
[18] *Id.*
[19] Issue Statement at 2.

duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[20], the Board dismisses this aspect of the SSI - Provider Specific issue.

Additionally, with regard to the data accuracy aspect of the issue, the Board finds that the Provider's PPP failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of any alleged "errors" in its PPP and include *all* exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents[21]**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[22]

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule:

> Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MEDPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to

[20] PRRB Rules v. 3.1 (Nov. 2021).
[21] PRRB Rules v. 3.1 (Nov. 2021)
[22] (Italics and underline emphasis added.)

> hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[23]

Additionally, in its PPP, the Provider states, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra [sic] (Appellants' reply brief included as Exhibit P-3)." The Board finds that this incorporation by reference does not comply with the regulatory and Board rule requirements to *fully* develop the Provider's position in the PPP. Particularly 42 C.F.R. § 405.1853 provides in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[24]

An incorporation of arguments by reference from a different case simply fails to do so. Accordingly, the Board dismisses that portion of the issue as well.

2. Second Aspect of Issue 1

The second aspect of the SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Moreover, without this written request, the MAC cannot issue a final determination with which the Provider can be dissatisfied for Board appeal purposes. There is nothing in the record to indicate the MAC has made a final determination regarding DSH SSI Percentage realignment. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

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[23] Last updated July 31, 2026.
[24] (Emphasis added).

B. DSH Payment – Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider's issue statement for Issue 3 is stated, *supra*.

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days that affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii), which places the burden of production on the provider states in pertinent part:

> The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) states:

> The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

Furthermore, 42 C.F.R. § 405.1853 addresses position papers and specifies in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.

> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[25]

Similarly, Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[26] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides instruction on the content of position papers as it relates to unavailable documentation/exhibits, as discussed *supra*.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's ***own motion***:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned;
- upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868);
- if the Board is unable to contact the provider or representative at the last known address; or
- upon failure to appear for a scheduled hearing.

Relative to a Medicaid Eligible Days determination, it is well-established that adequate data to prove eligibility for each Medicaid patient day claimed is a complete and accurate (i.e., auditable) Medicaid eligible days listing, which upon timely submission by a provider, a MAC can examine to make applicable adjustments.

This appeal was initiated on January 26, 2023 (more than 3.5 years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expect to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Provider's PPP indicated that it would be sending the eligibility listing under separate cover.[27] ***To-date, no listing has been provided.*** Accordingly, the Provider has abandoned the issue by failing to properly develop its arguments and provide supporting documents, and by failing to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[28] Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3)

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[25] (Emphasis added).
[26] (Emphasis added).
[27] Provider's PPP at 9.
[28] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.

C. 1115 Waiver Days

The Board finds that the Section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the Section 1115 Waiver days.

The regulations in effect when this appeal was filed with the Board in January of 2023 required the following:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing in the manner prescribed by the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.[29]

Board Rule 7.2.1 elaborated on this regulatory requirement, instructing providers:

The following information and supporting documentation must be submitted for each issue raised in the appeal request.

- An issue title and a concise issue statement describing:
  - the relevant adjustment(s), including the adjustment number(s),
  - the controlling authority (*e.g.*, specific regulation, Federal Register issuance, manual provision, or Ruling),
  - why the adjustment(s) is incorrect,
  - how the payment should be determined differently,
  - the reimbursement effect, and
  - the basis for jurisdiction before the Board.

[29] 42 C.F.R. § 405.1835(b).

Board Rule 8 explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these examples are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[30]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[31]

42 C.F.R. § 405.1835(e) provides in relevant part:

> (e) Adding issues to the hearing request. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
> . . .
>
> (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

In practice, this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider added the Section 1115 Waiver days to the case properly or timely.

In this regard, the Board notes that Section 1115 Waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[32] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program and not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) states in pertinent part:

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[30] (Bold and italic emphasis added).
[31] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[32] 65 FR 47054, 47087 (Aug. 1, 2000).

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.**
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for **each** Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Because the Provider did not raise the Section 1115 Waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The DSH Medicaid Eligible Days issue as stated in the original appeal request cannot be construed to include Section 1115 Waiver days. Additionally, there is no indication that any 1115 Waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

Regardless, even if the Provider had included in its appeal request (***which it did not***), the Provider failed to properly develop the issue in its PPP filing as it does not identify the specific 1115 waiver day program(s) at issue). In addition, the PPP does not discuss whether or not the Section 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the PPP is perfunctory in that it only

makes cursory conclusions.[33] Again, the Provider failed to so develop its PPP, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 23 (Nov. 2021).

As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* Section 1115 waiver days sub-issue.

The Board's finding that neither the appeal request nor the PPP met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[34] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[35] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[36] The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[37] Here, the Board makes the same finding based on similarly *overly generalized language.*

****

Based on the foregoing, the Board is dismissing the SSI - Provider Specific - Issue No.1 and Medicaid Eligible Days (*including Section 1115 Waiver Days*)- Issue No. 3 from this case.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

---

[33] For example, CHS cites to *Forrest General Hosp.*, 926 F.3d 221 (5th Cir. 2019) for the proposition that "the plain language of the statute and regulations require inclusion in the Medicaid Fraction of the days belong to individual who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool." However, CHS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is CHS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? CHS fails to brief the merits of its claims and fails to establish the Board's jurisdiction over the § 1115 waiver day issue as required by 42 C.F.R. § 405.1853(b)(2). Indeed, the quoted sentence is the only time the PPP references "uncompensated care pool."
[34] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[35] *Id*. at *11.
[36] *Id.*
[37] *Id.*

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For the Board:

9/22/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran, President
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RE: ***Board Decision – Dismissal of DSH Payment/SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues***
Poplar Bluff Regional Medical Center (Prov. No. 26-0119), FYE 12/31/2018
Case No. 23-0526

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-0526. Set forth below is the background of the case and the Board's decision related to the issues challenging the SSI-Provider Specific and Medicaid Eligible Days issues.

Background:

A. ***Procedural History for Case No. 23-0526***

On **August 4, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2018.

On **January 13, 2023**, Community Health Systems ("CHS") filed an appeal on behalf of the Provider. The Appeal Request included five (5) issues:

1. DSH Pymt/SSI % (Provider Specific)
2. DSH/SSI - Unduly Narrow Definition of SSI Entitlement[1]
3. DSH Pymt - Medicaid Eligible Days
4. Medicare Managed Care Part C - SSI & Medicaid Fractions[2]
5. Dual Eligible Days - SSI and Medicaid Fractions[3]

The Provider is commonly owned by CHS, so it is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1).

[1] On August 7, 2023, CHS transferred this issue to an SSI Systemic Errors CIRP Group, Case No. 21-1206GC. On August 7, 2026, the Board subsequently denied the transfer because it determined the issues were not the same. On August 12, 2026, QRS transferred the issue to a new Unduly Narrow CIRP group under Case No. 26-2711GC.
[2] On August 7, 2023, this issue was transferred to Case No. 20-2149GC.
[3] On August 7, 2023, this issue was transferred to Case No. 21-0066GC.

On **January 17, 2023**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates ("ACDD"), providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter* "PPP".) This Notice also gave the following instructions to the Provider regarding the content of its PPP:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[4]

On **August 22, 2023**, CHS filed the Provider's PPP.

On **December 15, 2023**, the Medicare Contractor ("MAC") filed a jurisdictional challenge.

On **December 22, 2023,** the MAC filed its PPP.

On **August 4, 2026**, the case was scheduled for a hearing on March 12, 2027.

On **August 11, 2026,** CHS filed a change in representation to Quality Reimbursement Services, Inc. ("QRS") which the Board acknowledged the same day.

B. Description of Issue 1 in the Appeal Request

In its Individual Appeal Request, the Provider summarizes its SSI Percentage (Provider Specific) issue as follows:

> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that

[4] (Emphasis added.)

> CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator'. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[5]

On August 22, 2023, the Board received the Provider's PPP in Case No. 23-0526. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[6]

[5] Issue Statement at 1.
[6] Provider's PPP at 7-8.

The amount in controversy listed for both Issue 1 and Issue 2 in the Provider's individual appeal request is $56,815.

Description of Issue 3 in the Appeal Request

In its Individual Appeal Request, the Provider questions whether the MAC properly excluded Medicaid eligible days from the DSH calculation. The Statement of the Legal Basis is as follows:

> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.

The estimated reimbursement amount for this issue is $46,721.[7]

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[8] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[9]

The Provider then, for the first time in this appeal, states it is seeking reimbursement for section 1115 waiver days as a part of the Medicaid eligible day issue. Specifically, the Provider states:

> [M]edicaid eligible days (including section 1115 waiver days (where applicable), which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).

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[7] Issue Statement at 3.
[8] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[9] Provider's PPP at 8.

> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its 2018 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[10]

MAC's Contentions: Issue 1 – DSH SSI Provider Specific

In its jurisdictional challenge, the MAC argues that the Board lacks jurisdiction over the SSI-Provider Specific issue, which has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of the SSI issue under appeal in the CIRP group. The component related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies. Finally, the MAC asserts the SSI Provider Specific issue should be dismissed because the Provider did not file a complete PPP in accordance with 42 C.F.R. § 405.1853 and Board Rule 25.[11]

MAC's Contentions: Issue 3 – DSH Medicaid Eligible Days

The MAC also argues the Board lacks jurisdiction over the Medicaid Eligible Days issue. The MAC contends that the Provider failed to include a list of additional Medicaid eligible days they expect to be included with their appeal or their PPP, even though the Provider advised that it would send a listing of additional Medicaid eligible days under separate cover, and even after the MAC sent the Provider a request for the information.

The MAC also challenges the Provider's attempt to untimely add the Section 1115 Waiver Days issue by including it in the narrative of the PPP.[12] In addition, the MAC argues the Section 1115 Waiver Days is a separate and distinct issue.[13]

Provider's Jurisdictional Response

Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."[14] The Provider failed to file a timely response by the *January 14, 2024* deadline.

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[10] *Id.* at 8-9.
[11] MAC Jurisdiction Challenge at 2.
[12] *Id.* at 13.
[13] *Id.* at 14.
[14] Board Rule 44.4.3, v. 3.1 (Nov. 2021).

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby dismisses the Provider's Issue Nos. 1 and 3.

A. SSI Percentage (Provider Specific)

The analysis for Issue No. 1 has three relevant aspects to consider: (1) individuals who are eligible for SSI but did not receive SSI payment; (2) data accuracy and (3) SSI realignment.

1. First Aspect of Issue 1

The aspect of Issue No. 1 related to the Provider's disagreement with how the MAC computed the SSI percentage because of CMS' policy of excluding patients that were entitled to SSI from the numerator of the Medicare fraction—is duplicative of the Unduly Narrow Definition of SSI Entitlement issue that is being pursued as Issue #2.

The SSI- Provider Specific issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[15] Per the appeal request, the Provider's legal basis for its SSI Percentage (Provider Specific) issue asserts that the MAC "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[16] The Provider argues that "its'[sic] SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[17] Finally, the Provider argues that CMS inconsistently interprets the term "entitled" as used in the statute because it requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. "CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment." These arguments are restated in Issue No. 2 where the Provider points to CMS' policy of applying different interpretations to the term "entitled."[18]

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[15] Issue Statement at 1.
[16] *Id.*
[17] *Id.*
[18] Issue Statement at 2.

The Board finds that aspect of the issue related to the term "entitled" in Case No. 23-0526 is duplicative of the Unduly Narrow issue described at Issue No. 2, which was subsequently transferred to a CIRP group, Case No. 26-2711GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[19], the Board dismisses this aspect of the SSI - Provider Specific issue.

2. Second Aspect of Issue 1

With regard to the data accuracy aspect of the issue, the Board finds that the Provider's PPP failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of any alleged "errors" in its PPP and include *all* exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents[20]**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[21]

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule:

> Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MEDPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this

[19] PRRB Rules v. 3.1 (Nov. 2021).
[20] PRRB Rules v. 3.1 (Nov. 2021)
[21] (Italics and underline emphasis added.)

> provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[22]

Additionally, in its PPP, the Provider states, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra [sic] (Appellants' reply brief included as Exhibit P-3)." The Board finds that this incorporation by reference does not comply with the regulatory and Board rule requirements to *fully* develop the Provider's position in the PPP. Particularly 42 C.F.R. § 405.1853 provides in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[23]

An incorporation of arguments by reference from a different case simply fails to do so. Accordingly, the Board dismisses that portion of the issue as well.

3. Third Aspect of Issue 1

The aspect of the SSI Percentage (Provider Specific) issue related to the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period is also dismissed by the Board.

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Moreover, without this written request, the MAC cannot issue a final determination with which the Provider can be

[22] Last updated July 31, 2026.
[23] (Emphasis added).

dissatisfied for Board appeal purposes. There is nothing in the record to indicate the MAC has made a final determination regarding DSH SSI Percentage realignment. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

B. DSH Payment – Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider's issue statement for Issue 3 is stated, *supra*.

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days that affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii), which places the burden of production on the provider states in pertinent part:

> The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) states:

> The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

Furthermore, 42 C.F.R. § 405.1853 addresses position papers and specifies in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the*

> *relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[24]

Similarly, Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[25] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides instruction on the content of position papers as it relates to unavailable documentation/exhibits, as discussed *supra*.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's ***own motion***:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned;
- upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868);
- if the Board is unable to contact the provider or representative at the last known address; or
- upon failure to appear for a scheduled hearing.

Relative to a Medicaid Eligible Days determination, it is well-established that adequate data to prove eligibility for each Medicaid patient day claimed is a complete and accurate (i.e., auditable) Medicaid eligible days listing, which upon timely submission by a provider, a MAC can examine to make applicable adjustments.

This appeal was initiated on January 13, 2023 (more than 3.5 years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expect to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Provider's PPP indicated that it would be sending the eligibility listing under separate cover.[26] ***To-date, no listing has been provided.*** Accordingly, the Provider has abandoned the issue by failing to properly develop its arguments and provide supporting documents, and by failing to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[27]

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[24] (Emphasis added).
[25] (Emphasis added).
[26] Provider's PPP at 9.
[27] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of

Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.

C. 1115 Waiver Days

The Board finds that the Section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the Section 1115 Waiver days.

The regulations in effect when this appeal was filed with the Board in January of 2023 required the following:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing in the manner prescribed by the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.[28]

Board Rule 7.2.1 elaborated on this regulatory requirement, instructing providers:

The following information and supporting documentation must be submitted for each issue raised in the appeal request.

- An issue title and a concise issue statement describing:
  - the relevant adjustment(s), including the adjustment number(s),
  - the controlling authority (*e.g.*, specific regulation, Federal Register issuance, manual provision, or Ruling),
  - why the adjustment(s) is incorrect,
  - how the payment should be determined differently,
  - the reimbursement effect, and

its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

[28] 42 C.F.R. § 405.1835(b).

- the basis for jurisdiction before the Board.

Board Rule 8 explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these examples are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[29]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[30]

42 C.F.R. § 405.1835(e) provides in relevant part:

> (e) Adding issues to the hearing request. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
>
> . . .
>
> (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

In practice, this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider added the Section 1115 Waiver days to the case properly or timely.

In this regard, the Board notes that Section 1115 Waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[31] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program and not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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[29] (Bold and italic emphasis added).
[30] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[31] 65 FR 47054, 47087 (Aug. 1, 2000).

Specifically, § 412.106(b)(4) states in pertinent part:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.**
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for **each** Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Because the Provider did not raise the Section 1115 Waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The DSH Medicaid Eligible Days issue as stated in the original appeal request cannot be construed to include Section 1115 Waiver days. Additionally, there is no indication that any 1115 Waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

Regardless, even if the Provider had included in its appeal request (***which it did not***), the Provider failed to properly develop the issue in its PPP filing as it does not identify the specific 1115 waiver day program(s) at issue). In addition, the PPP does not discuss whether or not the Section 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the PPP is perfunctory in that it only

makes cursory conclusions.[32] Again, the Provider failed to so develop its PPP, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 23 (Nov. 2021).

As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* Section 1115 waiver days sub-issue.

The Board's finding that neither the appeal request nor the PPP met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[33] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[34] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[35] The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[36] Here, the Board makes the same finding based on similarly *overly generalized language.*

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Based on the foregoing, the Board is dismissing the SSI - Provider Specific - Issue No.1 and Medicaid Eligible Days (*including Section 1115 Waiver Days*)- Issue No. 3 from this case.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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[32] For example, CHS cites to *Forrest General Hosp.*, 926 F.3d 221 (5th Cir. 2019) for the proposition that "the plain language of the statute and regulations require inclusion in the Medicaid Fraction of the days belong to individual who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool." However, CHS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is CHS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? CHS fails to brief the merits of its claims and fails to establish the Board's jurisdiction over the § 1115 waiver day issue as required by 42 C.F.R. § 405.1853(b)(2). Indeed, the quoted sentence is the only time the PPP references "uncompensated care pool."

[33] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

[34] *Id*. at *11.

[35] *Id.*

[36] *Id.*

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For the Board:

9/22/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: **Corrected - Notice of Dismissals**
Case Number: 26-1960G - Hooper Lundy & Bookman CY 2006 Standardized Amt Predicate Fact Err 1986 BNAs Impact on DSH Group
Case Number: 26-1964G - Hooper Lundy & Bookman CY 2007 Standardized Amt Predicate Fact Err 1986 BNAs Impact on DSH Group
Case Number: 26-1968G - Hooper Lundy & Bookman CY 2008 Standardized Amt Predicate Fact Err 1986 BNAs Impact on DSH Group
Case Number: 26-2310G - Hooper Lundy & Bookman CY 2010 Standardized Amount Predicate Fact – 1986 BNA Impact on DSH Group
Case Number: 26-2311G - Hooper Lundy & Bookman CY 2010 Standardized Amount Base Rate Accur Impact on Medicare DSH Group

Dear Mr. Collins:

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the records in the above referenced appeals. The Board issued a decision on September 10, 2026, dismissing Cases 26-1960G, 26-1964G, 26-1968G, and 26-2310G. The Board is issuing this **corrected** decision to include Case 26-2311G, and its decision to do so is set forth below.

Procedural history:

These five (5) group appeals were filed between **March and April, 2026** and none of the groups are fully formed. All the participants are appealing from Revised NPRs ("RNPRs"). The "Notice of Reopening" accompanying the RNPRs is the Administrator's Remand Order, as well as Change Request 13294 (Feb. 21, 2024), which was issued to Medicare Contractors "to provide guidance for the treatment of Medicare Part C days in the calculation of a provider's Medicare Disproportionate Share Hospital adjustment."[1] The RNPRs all show a $0 change in Medicare reimbursement and specifically note they were issued as a result of Change Request 13294. The relevant audit adjustments for all group participants are either silent to any substantive adjustment or specifically reference that no updated figures were used to implement Change Request 13294.

[1] CMS Transmittal 12513, Change Request 13294 at 1 (Feb. 21, 2024).

None of the issue statements contain any substantive discussion of the RNPRs, audit adjustments, or explain how the Board has jurisdiction over the 1986 budget neutrality adjustment issue from the RNPRs. The appeals concern whether 1985 budget neutrality adjustments were unlawfully carried forward to 1986 and beyond, thus impacting present day IPPS rates.[2]

Relevant Law:

A. RNPR Appeals

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2023), which provides, in relevant part:

> (a) General. (1) A Secretary determination, a contractor determination, or a decision by a reviewing entity (as described in § 405.1801(a)) may be reopened, with respect to specific findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the contractor (with respect to contractor determinations), or by the reviewing entity that made the decision. . . .

Additionally, 42 C.F.R. § 405.1889 (2023)[3] explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) ***Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision***.
>
> (2) ***Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision***.[4]

As outlined above, when a final determination is reopened and revised, an appeal from the

[2] *E.g.*, Case No. 26-1960G, Issue Statement (Mar. 4, 2026).
[3] *See also Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).
[4] (Bold and italics emphasis added.)

revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[5]

B. Retroactive Part C Rule, Resulting RNPRs, and Associated Appeal Rights

i. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[6] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[7]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[8] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[9]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[10] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[11] The DPP is defined as the sum of two fractions expressed as percentages.[12] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), defines the Medicare/SSI fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[13]

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[5] 42 C.F.R. § 405.1889(b)(1).
[6] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[7] *Id.*
[8] *See* 42 U.S.C. § 1395ww(d)(5).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[12] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[13] (Emphasis added.)

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[14]

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[15]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[16]

ii. Establishment of Medicare Part C and Treatment of Part C Days in the DSH Calculation

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations ("HMOs") and competitive medical plans ("CMPs") is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to an eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A and enrolled under part B . . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days.

In the September 4, 1990 Federal Register, the Secretary[17] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR)

[14] 42 C.F.R. § 412.106(b)(2)-(3).
[15] (Emphasis added.)
[16] 42 C.F.R. § 412.106(b)(4).
[17] of Health and Human Services.

> file that allows us to isolate those HMO days that are associated with Medicare patients. Therefore, since that time we have been including HMO days in SSI/Medicare percentage [of the DSH adjustment].[18]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[19]

With the creation of Medicare Part C in 1997,[20] Medicare beneficiaries who are entitled to Medicare Part A benefits may elect to receive managed care coverage under Medicare Part C, and following that election, the beneficiary's benefits are no longer administered under Medicare Part A.[21] As part of the federal fiscal year ("FFY") 2004 IPPS proposed rule, the Secretary noted she had received "questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation." In response to those questions, the Secretary proposed "to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage" but rather "[t]hese patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[22] The Secretary did not finalize that policy in the FFY 2004 IPPS final rule because the Secretary had not yet completed review of the large number of comments received.[23]

In the FFY 2005 IPPS proposed rule, the Secretary referenced the Part C proposal in the FFY 2004 IPPS proposed rule and stated her intention to address the comments received on that proposal in the FY 2005 IPPS final rule.[24] In the FFY 2005 IPPS final rule, the Secretary purportedly changed her proposal/position by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[25] In response to a comment regarding this change, the Secretary explained that:

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[18] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[19] *Id.*
[20] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015*, codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[21] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[22] *Id.*
[23] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[24] 69 Fed. Reg. 28196, 28286 (May 18, 2004).
[25] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[26]

This statement would require inclusion of Medicare Part C inpatient days in the Medicare fraction of the DSH calculation.

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, it was not codified into the Code of Federal Regulations. The Secretary did not codify the policy change until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[27] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[28] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[29]

There has been substantial litigation over whether enrollees in Part C plans are "entitled to benefits" under Medicare Part A when determining their placement in either the DSH Medicare or Medicaid fraction.

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[26] *Id.* (emphasis added).
[27] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[28] *Id*. at 47411.
[29] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[30]

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[31] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[32] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[33] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for FFYs 2014 and beyond.[34] However, at that point, no new rule had been adopted for FFYs 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the Part C policy adopted in the FFY 2005 IPPS final rule. In 2014 the Secretary published Medicare fractions for FFY 2012 which included Part C days.[35] A number of hospitals appealed this action.[36] In *Azar v. Allina Health Services* ("*Allina II*"),[37] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[38] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[39] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[40]

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[30] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[31] 746 F. 3d 1102 (D.C. Cir. 2014).
[32] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[33] *Id.* at 2011.
[34] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[35] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[36] The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo**(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board, **pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[37] 139 S.Ct. 1804 (2019).
[38] *Id.* at 1817.
[39] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[40] 139 S.Ct. at 1814.

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[41] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[42]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[43] The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[44]

Finally, the following excerpts from the June 9, 2023 Final Rule discussing a hospital's right to challenge the Part C days policy adopted therein make clear that the Secretary did not consider the final rule or subsequent publication of SSI ratios to be an appealable "final determination":

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[41] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[42] CMS Ruling 1739-R at 1-2.
[43] 88 Fed. Reg. 37772 (June 9, 2023).
[44] 88 Fed. Reg. at 37788 (emphasis in original).

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports****. In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[45]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[46]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised* ***NPRs*** *will provide hospitals with a* ***vehicle to appeal*** *the new final action* even if the Medicare fraction or DSH payment does not change numerically."[47]

4. "*When the Secretary's treatment of Part C days in this final action is reflected* ***in NPRs and revised NPRs****, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation* ***by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[48]

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[45] 88 Fed. Reg. at 37774-75 (emphasis added).
[46] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[47] *Id.* at 37788 (emphasis added).
[48] *Id.* (emphasis added).

The above discussion in the preamble to the June 9, 2023 Final Rule makes clear that hospitals covered by that Final Rule would have appeal rights maturing with the yet-to-be-issued NPRs (original or revised) that would apply the finalized policy.

The Board also notes that, on September 30, 2025, the District Court for the District of Columbia issued a decision holding Part C enrollees are "entitled to [Part A] benefits" within the context of 42 U.S.C.§ 1395ww(d)(5)(F)(vi), even when they elect to receive Part C benefits.[49] It ruled, however, that the June 9, 2023 Final Rule is both impermissible retroactive[50] arbitrary and capricious.[51] The court ordered the parties to submit briefs on the appropriate remedy for the unlawful regulation,[52] and on August 28, 2026, the court vacated the June 9, 2023 Final Rule and remanded the case to the Secretary.[53] The time frame for the government to appeal this decision, however, has not yet elapsed.[54]

Decision of the Board:

A. Issues Appealed from RNPR

42 C.F.R. § 405.1889 governs the scope of appeals once a contractor determination is "reopened as provided in § 405.1885[.]" In this circumstance, Providers have *limited* appeal rights and are only able to appeal issues or matters that were "specifically revised" in the RNPRs.

The appeal rights detailed in the June 9, 2023 Final Rule specifically limit a provider's appeal rights to specific matters related to the actual RNPR (*i.e.*, the Part C Days policy). First, the Secretary made clear that the Part C Days rule could be appealed following the issuance of a new NPR or RNPR "***even if the Medicare fraction or DSH payment does not change numerically.***"[55] Thus, the new rule could be appealed even if the treatment of Part C Days was not "specifically revised."

The appeal rights, however, are strictly limited to the policy related to the treatment of Part C days. Following the issuance of a RNPR, the Secretary stated that Providers "***will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions contained in the NPRs or revised NPRs***[,]" "**will be able to challenge the agency's interpretation** [of the treatment of Part C days in this final action] by appealing those NPRs and revised NPRs[,]" and further stated that they "**can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[56]

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[49] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).
[50] *Id.* at *12-19.
[51] *Id.* at *19-22.
[52] *Id.* at *23.
[53] *Montefiore Med. Ctr. v. Kennedy*, 2026 WL 2547056, *14 (D.D.C. 2026).
[54] Fed. R. App. P. 4(a)(1)(B).
[55] 88 Fed. Reg. 37788 (emphasis added).
[56] *Id.* at 37787-88 (emphasis added).

The issue in these group appeals concerns whether 1985 budget neutrality adjustments were unlawfully carried forward to 1986 and beyond, thus impacting present day IPPS rates. The appeal of this issue was taken from RNPRs that were issued specifically to reflect and implement the treatment of Part C days as set forth in the June 23, 2023 Final Rule. The RNPRs make no changes at all to the Providers' payments or cost reports related to this specific issue. The Providers make no effort to demonstrate how these RNPRs or audit adjustments relate to this issue. The Providers make no mention of 42 C.F.R. § 405.1889(b)(1), which addresses what may be appealed from an RNPR such as those in these cases. The only appeal rights stem from the 2023 Final Rule, which are specifically tied to the implementation of the new Part C Rule. The Board also notes that none of the Providers in these groups appear to have appealed the budget neutrality adjustment carryforward issue when appealing from their original NPRs, and only seek to pursue this issue from RNPRs that did not make any specific adjustments related to the issue.

Additionally, the Board notes that 42 C.F.R. § 405.1835 addresses the right to a board hearing for individual provider appeals, and in particular, § 405.1835(b) requires the hearing request to demonstrate that the provider satisfies the requirements for a hearing (*i.e.* establish Board jurisdiction) for each item appealed:

> [t]he provider's request for a Board hearing under paragraph (a) of this section . . . ***must*** include the elements described in paragraphs (b)(1) through (4) of this section. . . .
>
> * * *
>
> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific identification of the final contractor or Secretary determination under appeal.[57]

Accordingly, the Board notes that 42 C.F.R. § 405.1835(a)(1) states:

> [t]he provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. ***Exception: If a final contractor determination is reopened under § 405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination*** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).[58]

[57] 42 C.F.R. § 405.1835(b) (bold and italics emphasis added).
[58] (Bold and italics emphasis added).

The right to establish a group is subject to parallel requirements at §§ 405.1837(c) and 405.1837(a)(1) respectively.[59] Further, Board Rule 4.1 (2023) states that "[t]he Board may review jurisdiction on its own motion at any time." Similarly, 42 C.F.R. § 405.1837(e)(2) specifies that "[t]he Board may make jurisdictional findings . . . at any time."[60] In the instant cases the Board has done so, and has determined that the Providers have not met their burden to prove that the Board has jurisdiction, in accordance with the regulations at 42 C.F.R. §§ 405.1835(b)(1), 405,1837(c)(1), and 405.1889(b)(1), in these group appeals.

Conclusion:

The issue in these cases, taken from the Providers' RNPRs, concerns whether 1985 budget neutrality adjustments were unlawfully carried forward to 1986 and beyond, thus impacting present day IPPS rates. The appeal of this issue was taken from RNPRs that were issued specifically to reflect and implement the treatment of Part C days as set forth in the June 9, 2023 Final Rule. The RNPRs made no changes at all to the Providers' payments or cost report related to the issue under appeal in these cases. The Providers make no effort to demonstrate how these RNPRs or audit adjustment relates to this issue to establish the Board's jurisdiction over these appeals notwithstanding their obligation to do so under 42 C.F.R. §§ 405.1835(b) and 405.1837(c).

The Board has reviewed the records in these cases and finds that (1) the RNPRs did not make "specific revisions" related to whether 1985 budget neutrality adjustments were unlawfully carried forward to 1986 and beyond, thus impacting present day IPPS rates and, as a result, pursuant to 42 C.F.R. § 405.1889(b)(1), that issue is beyond the scope of any appeal from the RNPRs, and (2) the only appeal rights afforded from the RNPRs as set forth in the June 9, 2023 Final Rule are to challenge the treatment of Part C Days in the RNPRs.[61] Based on the foregoing, the Board is hereby ***dismissing*** Cases 26-1960G, 26-1964G, 26-1968G 26-2310G, and 26-2311G.[62]

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[59] In particular, 42 C.F.R. § 405.1837(c) states, in pertinent part: "The request for a Board hearing as a group appeal must be submitted in writing to the Board, and the request must include all of the following: (1) A demonstration that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section."

[60] The only specified limitation is that the Board may not dismiss a group for failure to meet the amount in controversy requirement until after the group is fully formed.

[61] The Board notes that Courts have upheld the Board's application of providers' limited appeal rights under 42 C.F.R. § 405.1889(b). *See, e.g., HCA Health Servs. of Okla. v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994); *McLaren Flint v. Azar*, 464 F. Supp. 3d 1 (D.D.C. 2020); *St. Mary's of Mich. v. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *Franciscan St. Margaret Health v. Azar*, 407 F. Supp. 3d 28 (D.D.C. 2019); *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *Illinois-Masonic Med. Ctr. v. Sebelius*, 859 F. Supp. 2d 137 (D.D.C. 2012).

[62] The Board also notes that Cases 26-2310G and 26-2311G contain the same two providers appealing from the same RNPRs. Though the two cases have different case names, the group issue statements are identical. Board Rule 4.6.1 (2023) specifically prohibits providers from appealing or pursuing the same issue from a single final determination in more than one appeal. Since both appeals concern the same providers, same final determinations, and same group issue, the Board finds that this prohibited duplicate appeal serves as an alternative independent basis for dismissal of Case 26-2311G.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq. (abstaining)[63]
Shakeba DuBose, Esq.
Clayton J. Nix, Esq.

For the Board:

9/23/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: KEVIN D. SMITH -A

cc: Wilson Leong, Esq. Federal Specialized Services
Dana Johnson, Palmetto GBA c/o Wellpoint Federal Solutions, Inc. (J-M)
Cecilia Lukito, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Syrie Cauthen, Wellpoint Federal Solutions, Inc. (J-6)

[63] Board Member Musgrave declines to render an opinion on this matter. It is her contention that the Medicare Contractor has a responsibility to make its own legal and factual argument supporting a jurisdictional challenge (Board Rule 44.1) and that the Providers should be given the opportunity to file response (Board Rule 44.3). She acknowledges that the Board may review jurisdiction on its own motion at any time (Board Rule 4.1). However, rather than forestall the Medicare Contractor's challenge with the Board's "Own Motion" determination, she would prefer that the Board instead allow the parties to present their own positions.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Notice of Dismissal***
Alliance Health Woodward (Prov. No. 37-0002), FYE 05/31/2020, Case No. 24-0300

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 24-0300. Set forth below is the decision of the Board to dismiss the two remaining issues in this appeal: the SSI Provider Specific and Medicaid Eligible Days issues.

Background

A. *Procedural History for Case No. 24-0300*

On **June 7, 2023**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end May 31, 2019.

On **October 17, 2022**, Community Health Systems, Inc. ("CHS") filed the Provider's appeal request. The request included four (4) issues:

1. DSH Pymt/ SSI% (Provider Specific)
2. DSH Pymt - Medicaid Eligible Days
3. Medicare Managed Care Part C Days – SSI & Medicaid Fraction[1]
4. Dual Eligible Days –SSI & Medicaid Fraction[2]

The Provider is commonly owned by CHS so it is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1).

On **December 4, 2023**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position

[1] On July 1, 2024, this issue was transferred to Case No 24-1806GC.
[2] On August 28, 2024, the Board bifurcated this issue into separate issues for the SSI and Medicaid Fractions. On October 1, 2024, the SSI Fraction DE day issue was transferred to Case No. 24-1804GC and the Medicaid Fraction DE issue was transferred to Case No. 24-1805GC.

papers (*hereinafter* "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 25.[3]

On **July 24, 2024**, CHS timely filed the Provider's PPP.

On **September 17, 2024**, the Medicare Contractor ("MAC") filed a jurisdictional challenge over the two remaining issues: DSH SSI Provider Specific & Medicaid eligible days.

On **September 17, 2024**, CHS requested a change of representation to Quality Reimbursement Services, Inc. ("QRS"), which the Board granted on **September 18, 2024**.

On **October 25, 2024**, the MAC timely filed its PPP.

B. Description of Issue 1 in the Appeal Request

In its Individual Appeal Request, the Provider summarizes its DSH SSI Provider Specific issue as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).[4]

[3] (Emphasis added).
[4] Issue Statement at 1.

On June 12, 2023, the Board received the Provider's PPP in Case No. 24-0300. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of *Advocate Christ Medical Center, et al, v Xavier Becerra* (Appellants' reply brief included as Exhibit P-3).[5]

The amount in controversy listed for the SSI Percentage Provider Specific (Issue 1) is $6,476.

Description of Issue 2 in the Individual Appeal Request

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations. The Provider describes Issue 2 as:

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**

[5] Provider's PPP at 8-9.

> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 12, 13, S-D
> Estimated Reimbursement Amount: $24,836[6]

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[7] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[8]

In addition, for the first time, the Provider mentions Section 1115 Waiver days:

> Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover a redacted copy is attached), the Provider contends that the total number of days reflected in its 2020 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court

[6] Issue Statement at 3.
[7] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[8] Provider's PPP at 9.

decisions.[9]

MAC's Contentions - Issue 1 –SSI Provider Specific

In its Jurisdictional Challenge, the MAC argues that the Board lacks jurisdiction over the DSH – SSI Provider Specific issue which involves two components: SSI data accuracy and realignment. The MAC argues the provider did not fully brief the realignment or data accuracy issue in its PPP. The Provider failed to include all supporting exhibits to document the merits of its argument as required in 42 C.F.R. § 405.1853(b)(2) and Rule 25. In addition, the MAC maintains that there was no final determination over the SSI realignment so the appeal of this aspect of the issue is premature.[10]

MAC's Contentions - Issue 2 – Medicaid Eligible/Section 1115 Waiver Days

In its Jurisdictional Challenge, the MAC rgues that the Provider abandoned the Medicaid Eligible Days issue when it failed to properly develop its arguments within the PPP in accordance with 42 C.F.R. § 405.1853 and Board Rule 25. Additionally, the Provider failed to provide a list of additional Medicaid eligible days or any other supporting documents and did not provide an explanation for why it could not produce those documents.

Additionally, the MAC contends the Provider is attempting to add the Section 1115 Waiver days issue improperly and untimely. The Section 1115 Waiver days were not part of the initial appeal request nor were they addressed in the PPP. It was not until the final PP submission that the Provider mentioned the issue.[11]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[12] The Provider failed to file a response by the deadline and the time for doing so elapsed as the deadline was October 17, 2024 (30 days after the September 17, 2024 filing). Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is

[9] Provider's PPP at 9-10.
[10] MAC's Jurisdictional Challenge at 2.
[11] *Id* at 2.
[12] Board Rule v. 3.1 (Nov. 1, 2021).

dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby ***dismisses*** the Provider's SSI Provider Specific and Medicaid Eligible Days issues.

A. SSI Provider Specific

The Provider's main argument regarding Issue No. 1 concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[13] Per the appeal request, the Provider's legal basis for its DSH SSI Provider Specific issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[14] In the issue statement filed with the appeal request, the Provider argued, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[15]

The Board has previously noted that CMS' interpretation of the SSI percentage regulation is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations, and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[16] Accordingly, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced.

To this end, the Board also reviewed the Provider's PPP and finds that it failed to comply with Board Rule 25 (Nov. 2021) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Nov. 2021), the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of the any alleged "errors" and include *all* exhibits. For example, the Provider fails to explain how it can ascertain from State records, the entitlement of individuals, how that information is relevant, and whether such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2. Moreover, the Provider has failed to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

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[13] Issue Statement at 1.
[14] *Id.*
[15] *Id.*
[16] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

25.2.2 Unavailable and Omitted Documents (Nov. 21, 2021)

> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[17]

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule

> "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[18]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not

[17] (Italics and underline emphasis added.)
[18] Last modified July 31, 2026.

explain what information it needs or is waiting on, or discuss claims to which it should have access.

Accordingly, *based on the record before it*,[19] the Board finds that the SSI Provider Specific issue in Case No. 24-0300 was not fully briefed in the PPP. Therefore, the ***Board dismisses this component of the SSI Provider Specific*** issue from Case No. 24-0300.

The other aspect of the SSI Provider Specific issue, related to the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period, is also dismissed by the Board. Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ". Moreover, without this written request, the MAC cannot issue a final determination with which the Provider can be dissatisfied for Board appeal purposes. There is nothing in the record to indicate the MAC has made a final determination regarding an SSI Percentage realignment. In accordance with 42 C.F.R. § 405.1835(a)(1), the ***Board dismisses this aspect of the SSI Provider Specific issue*** from the appeal.

B. DSH Payment – Medicaid Eligible Days

1. *Medicaid Eligible Days*

The Provider did not include a finalized list of the specific additional Medicaid eligible days that are in dispute in this case in the initial appeal.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Nov. 2021) states:

> **No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the

[19] Again, the Board notes that the Provider failed to timely respond to the Jurisdictional Challenge so the Board must make its determination based on the record before it.

> appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[20]

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Board Rule 25 (Nov. 2021) requires the Provider to file its complete, *fully* developed PPP with all available documentation and gives the following instruction on the content of position papers:

> **Rule 25 Preliminary Position Papers**[21]
>
> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the following sub-sections.
>
> **25.1.1 The Provider's Position Paper**
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.)

[20] (Bold emphasis added.)
[21] (Underline emphasis added to these excerpts and all other emphasis in original.)

and require no further documentation to be submitted.

B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
D. Provide a conclusion applying the material facts to the controlling authorities.

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to the Board

Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The December 4, 2023 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 2, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[22]

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at

[22] (Emphasis added.)

the last known address, or
- upon failure to appear for a scheduled hearing.

On July 24, 2024, the Provider filed its PPP paper in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.[23] The Provider's briefing of this issue in its PPP is stated *supra*.

In its September 17, 2024 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid Eligible days issue because the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable) with its appeal request or its PPP in violation of 42 CFR §405.1853 and Board Rule 25.3. Thus, the MAC asserts that the Provider has essentially abandoned the issue.[24] In addition, the MAC indicated the Provider was attempting to untimely and improperly add the issue of Section 1115 waiver days by including the issue in its PPP. The MAC pointed out that, although the waiver days issue is a component of the Medicaid Eligible days issue, it is considered a separate and distinct issue.

The Board concurs with the MAC- that the Provider is required to identify *the material facts* (*i.e.*, the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(4)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Provider failed to fully develop the merits of the Medicaid Eligible days issue because it failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue.

The Board recognizes that the Provider filed a redacted Eligible Days listing as an exhibit to its PPP, however:

1. An *auditable* version of the 2-page listing files as Exhibit P-1 was not provided to the MAC;
2. The 2-page redacted listing shows 165 "Additional ME Days" but includes the caveat "Listing pending finalization upon receipt of State eligibility data." The 165 days is exponentially larger than the original estimate included with the individual appeal which included only 40 days. In addition, there was no support accompanying the exhibit.

[23] Provider's PPP at 10.
[24] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

3. The Provider did not include an explanation as to why the first time it was filing the ME days listing was more than 4 years after the fiscal year at issue had closed and almost 8 months after the appeal was filed, nor did it explain why the listing was not yet final.

The Board finds that the Provider has essentially abandoned the Medicaid Eligible days issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.

2. *Section 1115 Waiver Days*

The Board finds that the Section 1115 waiver days issue is not a part of this appeal as it was not included as a cost issue in the appeal, nor was it properly or timely added. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from Section 1115 waiver days.

The appeal was filed with the Board in November of 2023 and the regulations required the following:

> b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) how and why the provider believes Medicare payment must be determined differently for each disputed item…[25]

Board Rule 7.2.1 (Nov. 2021) elaborated on this regulatory requirement instructing providers:

> The following information and supporting document must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
> - the adjustment, including the adjustment number,
> - the controlling authority,
> - why the adjustment is incorrect,

[25] 42 C.F.R. § 405.1835(b).

- how the payment should be determined differently,
- the reimbursement effect, and
- the basis for jurisdiction before the Board.[26]

Board Rule 8 (Nov. 2021) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these examples are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include…***Section 1115 waiver days (program/waiver specific)***[27]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[28] 42 C.F.R. § 405.1835(e) provides in relevant part:

> (c) *Adding issues to the hearing request*. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
> . . .
>
> (2) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

In practice this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider properly or timely added the Section 1115 waiver days issue to the case.

In this regard, the Board notes that Section 1115 waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[29] Rather, they relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 waiver days. Indeed, not every state Medicaid program has a qualifying 1115

[26] v. 3.1 (Nov. 2021).
[27] (Bold and italic emphasis added).
[28] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[29] 65 FR 47054, 47087 (Aug. 1, 2000).

expansion program ***and*** not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction.[20] In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) (2019) states in pertinent part:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act**.
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Because the Provider did not raise the Section 1115 waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The Medicaid eligible days issue as stated in the original appeal request cannot be construed to include Section 1115 waiver days. Additionally, there is no indication that any Section 1115 waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

Regardless, even if the Provider had included the Section 1115 waiver days issue in its appeal request (which it did not), the Provider failed to properly develop the issue in its PPP filing. The Provider's PPP does not identify the specific 1115 waiver day program(s) at issue) notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3)

and 412.106(b)(4)(iii) and Board Rule 25 (2021). Pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* Section 1115 waiver days sub-issue.

The Board's finding that neither the appeal request nor the PPP met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[30] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[31] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[32] The Court found that this description of the issue was a violation of Board rules and a proper basis for the Board to dismiss the appeal.[33] Here, the Board makes the same finding based on similar *overly generalized language*.

Based on the above, the Board finds that ***the appeal did not include the alleged Section 1115 waiver days sub-issue*** consistent with 42 C.F.R. §§ 405.1835(b)(2)-(3), 412.106(b)(4)(iii), and 405.1871(a)(3) and Board Rules 7.1, 8, 25, and 27.2.[34] In the alternative, the Board finds that, even if it had been included as part of the appeal, the issue was not properly developed in the PPP process.

* * * *

Based on the foregoing, the Board is ***dismissing the SSI Provider Specific and Medicaid Eligible Days/Section 1115 Waiver Days issues*** in this case. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

---

[30] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[31] *Id*. at *11.
[32] *Id.*
[33] *Id.*
[34] If section 1115 waiver days were found to be part of the appeal request and had been properly briefed, the Board would still need to address an additional jurisdictional issue – review whether it had jurisdiction over the section 1115 waiver days. For example, the Board has found that when a class of days (*e.g*., 1115 waiver days) is excluded due to choice, error, and/or advertence from the as-filed cost report, then that class of days is an unclaimed cost for which the Board would lack jurisdiction under 42 U.S.C. § 1395oo(a). *See, e.g.,* PRRB Jurisdictional Decision, Case Nos. 06-1851, 061852 (Nov. 17, 2017) (dismissing the class of adolescent psychiatric days from the appeal because no days were claimed with the as-filed cost report due to choice, error and/or inadvertence and, as such, the practical impediment standard or futility concept in the *Norwalk* and *Danbury* Board decisions is not applicable).

Board Members:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.
Clayton J. Nix, Esq.

For the Board:

9/24/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Byron Lamprecht, WPS Government Health Admin. (J-5)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Nathan Summar, V.P. Revenue Management
Community Health Systems, Inc.
4000 Meridian Boulevard
Franklin, TN 37067

RE: ***Notice of Own Motion Dismissal***
Lea Regional Medical Center (Provider Number 32-0065)
FYE: 12/31/2018
Case Number: 23-1726

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-1726. Set forth below is the Board's Own Motion decision to dismiss the remaining issue in this appeal: the DSH SSI Provider Specific issue.

Background

A. *Procedural History for Case No. 23-1726*

On **March 29, 2023**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2018.

On **September 21, 2023**, Community Health Services, Inc. ("CHS") the parent organization, filed the individual appeal for Lea Regional Medical Center which included four issues:

1. DSH Pymt/SSI% (Provider Specific)
2. DSH Pymt – Medicaid Eligible Days[1]
3. Medicare Managed Care Part C Days - SSI and Medicaid Fractions[2]
4. Dual Eligible Days - SSI and Medicaid Fractions[3]

Since the Provider is commonly owned/controlled by CHS, it is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). After the transfers of Issues 3 and 4 and the withdrawal of Issue 2, the only remaining issue is the SSI Provider Specific issue.

[1] On May 20, 2024, CHS withdrew this issue.
[2] On April 11, 2024, this issue was transferred to Case No. 20-2149GC.
[3] On April 11, 2024, this issue was transferred to Case No. 21-0066GC.

On **September 22, 2023**, the Board issued a Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter* "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 25.[4]

On **May 20, 2024**, the Provider filed its PPP and on September 11, 2024, the Medicare Contractor ("MAC") filed its PPP.

B. Description of Issue 1 in the Appeal Request

In its Individual Appeal Request, the Provider summarizes its DSH SSI Provider Specific issue as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed cause CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in its determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).[5]

On May 20, 2024, the Board received the Provider's PPP in Case No. 23-1726. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

---

[4] (Emphasis added).
[5] Issue Statement at 1.

Provider Specific

The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.

The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of *Advocate Christ Medical Center, et al, v Xavier Becerra* (Appellants' reply brief included as Exhibit P-2).[6]

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby ***dismisses*** the Provider's SSI Provider Specific issue in Case No. 23-1726.

A. SSI Provider Specific

One aspect of the SSI Provider Specific issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[7] Per the appeal

[6] Provider's PPP at 7-8 (May 20, 2024).
[7] Issue Statement at 1.

request, the Provider's legal basis for its DSH SSI Provider Specific issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[8] In the issue statement filed with the appeal request, the Provider argued, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[9]

The Board finds that the Provider failed to comply with Board Rule 25 governing the content of PPPs, in that the Provider failed to include any evidence to establish the material facts relating to inaccuracies in the SSI Percentage calculation at issue. Therefore, the Provider was in violation of Rule 25.3 because it failed to sufficiently develop the relevant facts and arguments to support its claim.

Moreover, as explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and failed to explain the nature of the any alleged "errors" and failed to include *all* exhibits. Board Rule 25.2.2, requires that the Provider explain the efforts made to obtain any documents which are missing or are unavailable.

Specifically, Board Rule 25.2.2 states:

> **25.2.2 Unavailable and Omitted Documents (Nov. 1, 2021)**
>
> If documents necessary to support your position are still unavailable, then provide the following information in the position papers:
>
> 1. *Identify* the missing documents;
> 2. *Explain why* the documents remain unavailable;
> 3. *State the efforts* made to obtain the documents; *and*
> 4. *Explain when* the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[10]

In this case, the Provider fails to explain how it can ascertain, from State records, the entitlement of individuals, how that information is relevant, and whether such a review was done for purposes of the year in question, consistent with its obligations under Board Rule 25.2. The Provider only cites to the 2000 Federal Register but additional issuances and developments on

[8] *Id.*
[9] *Id.*
[10] (Italics and underline emphasis added.)

the availability of data underlying the SSI fraction, such as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule

> "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."[11]

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[12]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276."[13] Here, the Provider does not explain what information it needs or is waiting on, nor does it discuss the claims to which it should have access.

Additionally, the Provider's PPP states, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra [sic] (Appellants' reply brief included as Exhibit P-3)."[14] The Board finds that this incorporation by reference does not comply with the

[11] 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005).
[12] Last modified July 31, 2026.
[13] *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346, 355 (D.C. Cir. 2023).
[14] Provider's PPP at 7-8.

regulatory and Board rule requirements to *fully* develop the Provider's position in the PPP. Particularly 42 C.F.R. § 405.1853 provides, in pertinent part:

> (b)(2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[15]

An incorporation of arguments by reference from a different case simply fails to do so. Accordingly, *based on the record before it*, the Board finds that this component of the SSI Provider Specific issue in Case No. 23-1726 has been abandoned.

The other aspect of the SSI Provider Specific issue, related to the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period, is also dismissed by the Board. Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting period instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ". Moreover, without this written request, the MAC cannot issue a final determination with which the Provider can be dissatisfied for Board appeal purposes. There is nothing in the record to indicate the MAC has made a final determination regarding an SSI Percentage realignment. In accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the SSI Provider Specific issue from the appeal.

Based on the foregoing, on its own motion, the Board is ***dismissing the SSI Provider Specific issue*** in this case. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

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Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.
Clayton J. Nix, Esq.

For the Board:

9/24/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: KEVIN D. SMITH -A

cc: Paul Zarling, Novitas Solutions, Inc. c/o Guidewell Source (J-H)
Wilson Leong, FSS

[15] (Emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: **Notice of Dismissals**

Case Number: 25-5142GC - Lee Memorial CY 2013 Medicare DSH - Medicare/SSI Fraction - Data Matching CIRP Group
Case Number: 26-0060GC - UNC Health CY 2007 Medicare DSH – SSI Days Matching Errors CIRP Group
Case Number: 26-2420GC - Emory Healthcare CY 2013 Medicare DSH – Medicare/SSI Fraction - Data Matching CIRP Group

Dear Mr. Collins and Ms. Carroll:

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the records in the above referenced appeals. The decision of the Board to ***dismiss*** the three (3) group appeals is set forth below.

Procedural history:

These three (3) group appeals were filed between **July, 2025 and April, 2026** and none of the groups are fully formed. All the participants are appealing from Revised NPRs ("RNPRs"). The "Notice of Reopening" accompanying the RNPRs was the Administrator's Remand Order, the Federal Register published June 9, 2023, and/or Change Request 13294 (Feb. 21, 2024), which was issued to Medicare Contractors "to provide guidance for the treatment of Medicare Part C days in the calculation of a provider's Medicare Disproportionate Share Hospital adjustment."[1] The RNPRs for all but one participant showed a $0 change in Medicare reimbursement and specifically note they were issued as a result of Change Request 13294. For Emory University Hospital Midtown (Provider Number 11-0078) in Case 26-2450GC, the RNPR noted $372,592 was due to the Provider, but also specifically noted it was being issued pursuant to the PRRB remand of 19-2477GC, which was a Part C Days case. The relevant audit adjustments for all group participants are either silent to any substantive adjustment or specifically reference that no updated figures were used to implement Change Request 13294.

None of the issue statements contain any substantive discussion of the RNPRs, audit adjustments, or explain how the Board has jurisdiction over the Data Matching issue from the

[1] CMS Transmittal 12513, Change Request 13294 at 1 (Feb. 21, 2024).

RNPRs. They explain that "[t]he numerator of the Medicare/SSI fraction should have, but did not, include all inpatient days relating to patients who were entitled to (1) benefits under Medicare Part A and (2) SSI benefits."[2]

Relevant Law:

A. RNPR Appeals

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2023), which provides, in relevant part:

> (a) General. (1) A Secretary determination, a contractor determination, or a decision by a reviewing entity (as described in § 405.1801(a)) may be reopened, with respect to specific findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the contractor (with respect to contractor determinations), or by the reviewing entity that made the decision. . . .

Additionally, 42 C.F.R. § 405.1889 (2023)[3] explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
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> (b)(1) ***Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision***.
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> (2) ***Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision***.[4]

As outlined above, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[5]

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[2] *E.g.*, Case No. 25-5142GC, Issue Statement (July 25, 2025).
[3] *See also Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).
[4] (Bold and italics emphasis added.)
[5] 42 C.F.R. § 405.1889(b)(1).

B. Retroactive Part C Rule, Resulting RNPRs, and Associated Appeal Rights

i. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[6] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[7]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[8] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[9]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[10] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[11] The DPP is defined as the sum of two fractions expressed as percentages.[12] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), defines the Medicare/SSI fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[13]

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[6] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[7] *Id.*
[8] *See* 42 U.S.C. § 1395ww(d)(5).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[12] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[13] (Emphasis added.)

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[14]

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[15]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[16]

ii. Establishment of Medicare Part C and Treatment of Part C Days in the DSH Calculation

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations ("HMOs") and competitive medical plans ("CMPs") is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to an eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A and enrolled under part B . . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days.

In the September 4, 1990 Federal Register, the Secretary[17] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR)

[14] 42 C.F.R. § 412.106(b)(2)-(3).
[15] (Emphasis added.)
[16] 42 C.F.R. § 412.106(b)(4).
[17] of Health and Human Services.

> file that allows us to isolate those HMO days that are associated with Medicare patients. Therefore, since that time we have been including HMO days in SSI/Medicare percentage [of the DSH adjustment].[18]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[19]

With the creation of Medicare Part C in 1997,[20] Medicare beneficiaries who are entitled to Medicare Part A benefits may elect to receive managed care coverage under Medicare Part C, and following that election, the beneficiary's benefits are no longer administered under Medicare Part A.[21] As part of the federal fiscal year ("FFY") 2004 IPPS proposed rule, the Secretary noted she had received "questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation." In response to those questions, the Secretary proposed "to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage" but rather "[t]hese patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[22] The Secretary did not finalize that policy in the FFY 2004 IPPS final rule because the Secretary had not yet completed review of the large number of comments received.[23]

In the FFY 2005 IPPS proposed rule, the Secretary referenced the Part C proposal in the FFY 2004 IPPS proposed rule and stated her intention to address the comments received on that proposal in the FY 2005 IPPS final rule.[24] In the FFY 2005 IPPS final rule, the Secretary purportedly changed her proposal/position by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[25] In response to a comment regarding this change, the Secretary explained that:

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[18] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[19] *Id.*
[20] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015*, codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[21] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[22] *Id.*
[23] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[24] 69 Fed. Reg. 28196, 28286 (May 18, 2004).
[25] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[26]

This statement would require inclusion of Medicare Part C inpatient days in the Medicare fraction of the DSH calculation.

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, it was not codified into the Code of Federal Regulations. The Secretary did not codify the policy change until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[27] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[28] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[29]

There has been substantial litigation over whether enrollees in Part C plans are "entitled to benefits" under Medicare Part A when determining their placement in either the DSH Medicare or Medicaid fraction.

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[26] *Id.* (emphasis added).
[27] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[28] *Id*. at 47411.
[29] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[30]

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[31] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[32] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[33] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for FFYs 2014 and beyond.[34] However, at that point, no new rule had been adopted for FFYs 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the Part C policy adopted in the FFY 2005 IPPS final rule. In 2014 the Secretary published Medicare fractions for FFY 2012 which included Part C days.[35] A number of hospitals appealed this action.[36] In *Azar v. Allina Health Services* ("*Allina II*"),[37] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[38] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[39] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[40]

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[30] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[31] 746 F. 3d 1102 (D.C. Cir. 2014).
[32] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[33] *Id.* at 2011.
[34] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[35] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[36] The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo**(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board, **pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[37] 139 S.Ct. 1804 (2019).
[38] *Id.* at 1817.
[39] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[40] 139 S.Ct. at 1814.

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[41] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[42]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[43] The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[44]

Finally, the following excerpts from the June 9, 2023 Final Rule discussing a hospital's right to challenge the Part C days policy adopted therein make clear that the Secretary did not consider the final rule or subsequent publication of SSI ratios to be an appealable "final determination":

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[41] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[42] CMS Ruling 1739-R at 1-2.
[43] 88 Fed. Reg. 37772 (June 9, 2023).
[44] 88 Fed. Reg. at 37788 (emphasis in original).

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports***. *In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[45]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[46]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised* ***NPRs*** *will provide hospitals with a* ***vehicle to appeal*** *the new final action* even if the Medicare fraction or DSH payment does not change numerically."[47]

4. "*When the Secretary's treatment of Part C days in this final action is reflected* ***in NPRs and revised NPRs****, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation* ***by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[48]

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[45] 88 Fed. Reg. at 37774-75 (emphasis added).
[46] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[47] *Id.* at 37788 (emphasis added).
[48] *Id.* (emphasis added).

The above discussion in the preamble to the June 9, 2023 Final Rule makes clear that hospitals covered by that Final Rule would have appeal rights maturing with the yet-to-be-issued NPRs (original or revised) that would apply the finalized policy.

The Board also notes that, on September 30, 2025, the District Court for the District of Columbia issued a decision holding Part C enrollees are "entitled to [Part A] benefits" within the context of 42 U.S.C.§ 1395ww(d)(5)(F)(vi), even when they elect to receive Part C benefits.[49] It ruled, however, that the June 9, 2023 Final Rule is both impermissible retroactive[50] arbitrary and capricious.[51] The court ordered the parties to submit briefs on the appropriate remedy for the unlawful regulation,[52] and on August 28, 2026, the court vacated the June 9, 2023 Final Rule and remanded the case to the Secretary.[53] The time frame for the government to appeal this decision, however, has not yet elapsed.[54]

Decision of the Board:

A. Issues Appealed from RNPR

42 C.F.R. § 405.1889 governs the scope of appeals once a contractor determination is "reopened as provided in § 405.1885[.]" In this circumstance, Providers have *limited* appeal rights and are only able to appeal issues or matters that were "specifically revised" in the RNPRs.

The appeal rights detailed in the June 9, 2023 Final Rule specifically limit a provider's appeal rights to specific matters related to the actual RNPR (*i.e.*, the Part C Days policy). First, the Secretary made clear that the Part C Days rule could be appealed following the issuance of a new NPR or RNPR "***even if the Medicare fraction or DSH payment does not change numerically.***"[55] Thus, the new rule could be appealed even if the treatment of Part C Days was not "specifically revised."

The appeal rights, however, are strictly limited to the policy related to the treatment of Part C days. Following the issuance of a RNPR, the Secretary stated that Providers "***will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions contained in the NPRs or revised NPRs***[,]" "**will be able to challenge the agency's interpretation** [of the treatment of Part C days in this final action] by appealing those NPRs and revised NPRs[,]" and further stated that they "**can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[56]

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[49] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).
[50] *Id.* at *12-19.
[51] *Id.* at *19-22.
[52] *Id.* at *23.
[53] *Montefiore Med. Ctr. v. Kennedy*, 2026 WL 2547056, *14 (D.D.C. 2026).
[54] Fed. R. App. P. 4(a)(1)(B).
[55] *Id.* (emphasis added).
[56] *Id.* at 37787-88 (emphasis added).

The issue in these group appeals is related to the SSI Data Matching process. The RNPRs make no changes at all to the Providers' payments or cost reports related to this specific issue. The Providers make no effort to demonstrate how these RNPRs or audit adjustments relate to this issue. The only appeal rights stem from the 2023 Final Rule, which are specifically tied to the implementation of the new Part C Rule. The Board also notes that none of the Providers in these groups appear to have appealed the SSI Data Matching issue when appealing from their original NPRs, and only seek to pursue this issue from RNPRs that did not make any specific adjustments related to the issue.

Additionally, the Board notes that 42 C.F.R. § 405.1835 addresses the right to a board hearing for individual provider appeals, and in particular, § 405.1835(b) requires the hearing request to demonstrate that the provider satisfies the requirements for a hearing (*i.e.* establish Board jurisdiction) for each item appealed:

> [t]he provider's request for a Board hearing under paragraph (a) of this section . . . must include the elements described in paragraphs (b)(1) through (4) of this section. . . .
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> * * *
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> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific identification of the final contractor or Secretary determination under appeal.[57]

Accordingly, the Board notes that 42 C.F.R. § 405.1835(a)(1) states:

> [t]he provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. ***Exception: If a final contractor determination is reopened under § 405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination*** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).[58]

The right to establish a group is subject to parallel requirements at §§ 405.1837(c) and 405.1837(a)(1) respectively.[59] Further, Board Rule 4.1 (2023) states that "[t]he Board may review jurisdiction on its own motion at any time." Similarly, 42 C.F.R. § 405.1837(e)(2)

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[57] 42 C.F.R. § 405.1835(b) (bold and italics emphasis added).
[58] (Bold and italics emphasis added).
[59] In particular, 42 C.F.R. § 405.1837(c) states, in pertinent part: "The request for a Board hearing as a group appeal must be submitted in writing to the Board, and the request must include all of the following: (1) A demonstration that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section."

specifies that "[t]he Board may make jurisdictional findings . . . at any time."[60] In the instant cases the Board has done so, and has determined that the Providers have not met their burden to prove that the Board has jurisdiction, in accordance with the regulations at 42 C.F.R. §§ 405.1835(b)(1), 405,1837(c)(1), and 405.1889(b)(1), in these group appeals.

Conclusion:

The issue in these cases, taken from the Providers' RNPRs, concerns the SSI Data Matching process. The appeal of this issue was taken from RNPRs that were issued specifically to reflect and implement the treatment of Part C days as set forth in the June 9, 2023 Final Rule. The RNPRs made no changes at all to the Providers' payments or cost reports related to the issue under appeal in these cases. The Providers make no effort to demonstrate how these RNPRs or audit adjustment relate to this issue to establish the Board's jurisdiction over these appeals notwithstanding their obligation to do so under 42 C.F.R. § 1835(b) and 405.1837(c).

The Board has reviewed the records in these cases and finds that (1) the RNPRs did not make "specific revisions" related to the SSI Data Matching issue and, as a result, pursuant to 42 C.F.R. § 405.1889(b)(1), that issue is beyond the scope of any appeal from the RNPRs, and (2) the only appeal rights afforded from the RNPRs as set forth in the June 9, 2023 Final Rule are to challenge the treatment of Part C Days in the RNPRs.[61] Based on the foregoing, the Board is hereby ***dismissing*** Cases 25-5142GC, 26-0060GC, and 26-2420GC.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

[60] The only specified limitation is that the Board may not dismiss a group for failure to meet the amount in controversy requirement until after the group is fully formed.

[61] The Board notes that Courts have upheld the Board's application of providers' limited appeal rights under 42 C.F.R. § 405.1889(b). *See, e.g., HCA Health Servs. of Okla. v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994); *McLaren Flint v. Azar*, 464 F. Supp. 3d 1 (D.D.C. 2020); *St. Mary's of Mich. v. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *Franciscan St. Margaret Health v. Azar*, 407 F. Supp. 3d 28 (D.D.C. 2019); *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *Illinois-Masonic Med. Ctr. v. Sebelius*, 859 F. Supp. 2d 137 (D.D.C. 2012).

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Shakeba DuBose, Esq.
Clayton J. Nix, Esq.

For the Board:

9/24/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: KEVIN D. SMITH -A

cc: Wilson Leong, Esq. Federal Specialized Services
Dana Johnson, Palmetto GBA c/o Wellpoint Federal Solutions, Inc. (J-M)
Geoff Pike, First Coast Service Options, Inc. c/o GuideWell Source (J-N)
Cecile Huggins, Palmetto GBA (J-J)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Blvd.
Mail Stop: B1-01-31
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

Nathan Summar, Vice President, Revenue Mgmnt
Community Health Systems, Inc.
4000 Meridian Boulevard
Franklin, TN 37067

RE: ***Notice of Dismissal***
Lake Granbury Medical Center (Prov. No. 45-0596), FYE 11/30/2021
Case No. 25-4630

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 25-4630. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 25-4630*

On **December 19, 2024**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end November 30, 2021.

On **June 5, 2025**, the Board received the Provider's individual appeal request. The Appeal Request was filed by Community Health Systems, Inc. ("CHS") and included five (5) issues:

1. DSH Pymt/SSI % (Provider Specific)[1]
2. DSH Pymt - Medicaid Eligible Days
3. Medicare Managed Care Part C – SSI & Medicaid Fractions[2]
4. Improper Rulemaking – SSI Fraction Dual Eligible Days[3]
5. Improper Rulemaking – Medicaid Fraction Dual Eligible Days[4]

The Provider is commonly owned by CHS, so it is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1).

On **June 6, 2025**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position

[1] On January 29, 2026, this issue was withdrawn.
[2] On December 8, 2025, this issue was transferred to Case No. 24-1834GC.
[3] On December 8, 2025, this issue was transferred to Case No. 24-1835GC.
[4] On December 8, 2025, this issue was transferred to Case No. 24-1836GC.

papers (hereinafter "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[5]

On **January 30, 2026**, CHS filed the Provider's PPP.

On **April 29, 2026,** the MAC filed its PPP.

On **April 30, 2026**, the MAC filed a Jurisdictional Challenge.

MAC's Contentions- DSH – Medicaid Eligible Days

The MAC contends that the Provider abandoned the Medicaid Eligible Days issue when it failed to include a list of additional Medicaid eligible days it expected to be included with its appeal or is PPP. Therefore, the issue was abandoned when the PPP was not filed in accordance with Board Rule 25.3 and 42 C.F.R. § 405.1853. Additionally, the Provider has failed to submit an unredacted, auditable list of additional Medicaid eligible days or any other supporting documents or explanation for why it cannot produce those documents.

The MAC also contends the Provider is attempting to untimely and improperly add the issue of Section 1115 waiver days via its PPP, filed on January 30, 2026. The MAC asserts that prior to the PPP, the Provider had not formally added the dispute to the appeal, nor had it otherwise raised the issue of Section 1115 waiver days.[6] Finally, the MAC argues that Section 1115 waiver days issue is one component of the DSH issue - and is a separate and distinct issue from Medicaid eligible days issue so it must be identified and appealed separately.[7]

Provider's Jurisdictional Response

Board Rule 44.4.3 requires that: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so elapsed on May 1, 2026.

---

[5] (Emphasis added.)
[6] MAC Jurisdiction Challenge at 8.
[7] *Id.*at 10.

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby ***dismisses*** the Provider's sole remaining issue.

A. DSH Payment – Medicaid Eligible Days

The Provider did not include a list of the specific additional Medicaid eligible days that are in dispute in the initial appeal.

With regard to the filing of an individual appeal, Board Rule 7 - Support for Appealed Final Determination, Availability of Issue-Related Information and Basis for Dissatisfaction (Dec. 2023) states:

> **No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[8]

[8] (Bold emphasis added.)

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Board Rule 25 (Dec. 2023) requires the Provider to file its complete, *fully* developed position paper with all available documentation and gives the following instruction on the content of position papers:

Rule 25 - Preliminary Position Papers[9]

> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the following sub-sections.

25.1.1 The Provider's Position Paper

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
D. Provide a conclusion applying the material facts to the controlling authorities.

[9] (Underline emphasis added to these excerpts and all other emphasis in original.)

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to the Board

Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The June 6, 2025 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with the Medicaid Eligible Days issue, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[10]

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On January 30, 2026, the Provider filed its PPP in which it indicated that the eligibility listing was imminent by promising that the listing was being sent to the MAC under separate cover.[11] The Provider's complete briefing of this issue in its PPP is as follows:

[10] (Emphasis added.)
[11] Provider's PPP at 9.

Calculation of Medicaid Eligible Days

The Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.

The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).

The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:

> [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.

Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).

> Based on the Listing of Medicaid Eligible days being sent under separate cover to the MAC (redacted listing to follow), the Provider contends that the total number of days reflected in its 2021 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.
>
> With respect to section 1115 waiver days, the courts have firmly rejected CMS's interpretation of its regulations, holding instead that the plain language of the statute and the regulations require inclusion in the Medicaid Fraction of the days belonging to individuals who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool. *See Forrest General Hospital*, 926 F.3d 221 (5th Cir. 2019); *HealthAlliance Hospitals, Inc. v. Azar*, 346 F. Supp. 3d 43(D.D.C. 2018); *Bethesda Health Inc., v. Azar*, 389 F. Supp. 3d 32, (D.D.C. 2019), *aff'd,* 980 F.3d 121 (D.C. Cir. 2020). CMS has acquiesced in *Bethesda* and is now following the statute and the plain meaning of its own regulations (which regulations represent the official policy of CMS all along) and properly accounting for 1115 Waiver days as Medicaid Eligible days. *See* CMS Manual Instructions System, Change Request 12669, Transmittal No. 11912 (March 16, 2023) ("Transmittal 11912"), attached as Exhibit P-3.[12]

In its April 30, 2026 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid Eligible days issue because the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable) with its appeal request or its PPP in violation of 42 CFR §405.1853 and Board Rule 25.3. Thus, the MAC asserts that the Provider has essentially abandoned the issue.[13] In addition, the MAC indicated the Provider was attempting to untimely and improperly add the issue of Section 1115 waiver days by including the issue in its PPP. The MAC pointed out that, although the waiver days issue is a component of the Medicaid Eligible days issue, it is considered a separate and distinct issue.

The Board concurs with the MAC- that the Provider is required to identify *the material facts* (*i.e.*, the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(4)(iii). Specifically, the Board finds that the Provider has failed to satisfy the

[12] Provider's PP at 8-10.
[13] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

requirements of 42 C.F.R. § 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Provider failed to fully develop the merits of the Medicaid Eligible days issue because it failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue.

The Board recognizes that the Provider filed a redacted Eligible Days listing as an exhibit to its PPP, however:

1. An *auditable* version of the 25-page listing at Exhibit P-1 was not provided to the MAC;
2. The 25-page redacted listing shows roughly 3,878 "Additional ME Days" but includes the caveat "Listing pending finalization upon receipt of State eligibility data." There was no support accompanying the exhibit.
3. The Provider did not include an explanation as to why the first time it was filing the ME days listing was more than 4 years after the fiscal year at issue had closed and almost 8 months after the appeal was filed, nor did it explain why the listing was not yet final.

The Provider has essentially abandoned the Medicaid Eligible days issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.

B. Section 1115 Waiver Days

The Board also concurs with the MAC, that the Section 1115 waiver days issue is not a part of this appeal as it was not properly or timely added. While the Provider appealed Medicaid Eligible days, this issue is separate and distinct from the Section 1115 waiver days.

The appeal was filed with the Board in June of 2025 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]

> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[14]

Board Rule 7.2.1 (2023) elaborated on this regulatory requirement, instructing providers:

> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
>   - the adjustment, including the adjustment number,
>   - the controlling authority,
>   - why the adjustment is incorrect,
>   - how the payment should be determined differently,
>   - the reimbursement effect, and
>   - the basis for jurisdiction before the [Board].

Board Rule 8 (Dec. 2023) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[15]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[16]

42 C.F.R. § 405.1835(e) provides in relevant part:

> (e) Adding issues to the hearing request. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
> . . .
> (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

[14] 42 C.F.R. § 405.1835(b).
[15] (Bold and italic emphasis added).
[16] *See* 73 Fed. Reg. 30190 (May 23, 2008).

In practice, this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider properly or timely added the Section 1115 waiver days issue to the case.

In this regard, the Board notes that Section 1115 waiver days are not traditional Medicaid Eligible days and, indeed, were only incorporated into the DSH calculation effective January 20, 2000.[17] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 waiver days. Indeed, not every state Medicaid program has a qualifying Section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a Section 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) (2019) states in pertinent part:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.**
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for **each** Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

[17] 65 FR 47054, 47087 (Aug. 1, 2000).

Because the Provider did not raise the Section 1115 waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The Medicaid Eligible days issue as stated in the original appeal request cannot be construed to include Section 1115 waiver days. Additionally, there is no indication that any Section 1115 Waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

Regardless, even if the Provider had included in its appeal request (***which it did not***), the Provider failed to properly develop the issue in its PPP filing as it does not identify the specific 1115 waiver day program(s) at issue). In addition, the PPP does not discuss whether or not the Section 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the PPP is perfunctory in that it only makes cursory conclusions.[18] Again, the Provider failed to so develop its PPP, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 23 (Dec. 2023).

As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* Section 1115 waiver days sub-issue.

The Board's finding that neither the appeal request nor the PPP met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[19] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[20] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor

[18] For example, CHS cites to *Forrest General Hosp.*, 926 F.3d 221 (5th Cir. 2019) for the proposition that "the plain language of the statute and regulations require inclusion in the Medicaid Fraction of the days belong to individual who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool." However, CHS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is CHS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? CHS fails to brief the merits of its claims and fails to establish the Board's jurisdiction over the § 1115 waiver day issue as required by 42 C.F.R. § 405.1853(b)(2). Indeed, the quoted sentence is the only time the PPP references "uncompensated care pool."

[19] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

[20] *Id*. at *11.

how the fraction should have been calculated differently."[21] The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[22] Here, the Board makes the same finding based on similar *overly generalized language.*

* * * * *

Based on the foregoing, the Board dismisses the sole remaining issue in this case – Medicaid Eligible days (including Section 1115 waiver days.) As no issues remain, the Board hereby closes Case No. 25-4630 and removes it from the Board's docket.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.
Clayton J. Nix. Esq.

For the Board:

9/28/2026

X Nicole E. Musgrave

Nicole E. Musgrave, Esq.
Board Member
Signed by: Nicole Musgrave-burdette -S

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson Leong, FSS

[21] *Id.*
[22] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran, President
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Notice of Dismissal***
Barnes Jewish Hospital (Provider Number 26-0032)
FYE: 12/31/2019
Case Number: 24-0494

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 24-0494. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's DSH SSI Percentage (Provider Specific) issue.

Background:

A. *Procedural History for Case No. 24-0494*

On **August 16, 2023**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2019. The Provider is commonly owned by BJC Health ("BJC").

On **December 14, 2023**, Quality Reimbursement Services, Inc. ("QRS") filed the Provider's individual appeal request which included two (2) issues:

1. DSH SSI Percentage (Provider Specific)
2. DSH Payment – Medicaid Eligible Days[1]

As the Provider is commonly owned/controlled by BJC, it is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1).

On **January 5, 2024**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers ("PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the

[1] On July 17, 2024, this issue was withdrawn.

> appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[2]

On **August 9, 2024**, the Provider timely filed its PPP.

On **October 7, 2024**, the Medicare Contractor ("MAC") filed a jurisdictional challenge. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **November 15, 2024**, the MAC timely filed its PPP.

B. Description of Issue 1 in the Individual Appeal Request and the Provider's Participation in Case No. 23-0397GC

In its Individual Appeal Request, the Provider summarizes its DSH- SSI Provider Specific issue as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days

[2] (Bold, italics, and underline emphasis added.)

> of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[3]

Also on December 14, 2023, the Provider was directly added to the "BJC Healthcare CY 2019 DSH SSI Unduly Narrow Definition of SSI Entitlement CIRP Group," Case No. 23-0397GC. The group issue statement in Case No. 23-0397GC includes the following excerpt:

> The Provider(s) protest(s) CMS's policy of excluding unpaid SSI days from the numerator of the Medicare fraction. Despite CMS's seemingly contrary policy of treating unpaid Part A days as days entitled to benefits under Part A, CMS requires that a beneficiary be paid SSI benefits (or "covered" by SSI) during the period of his or her hospital stay in order for such days to be considered "entitled to supplemental security income benefits" and included in the numerator of the SSI fraction.[4]

On August 9, 2024, the Board received the Provider's PPP in Case No. 24-0494. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District

[3] Issue Statement at 1 (Dec. 14, 2023).
[4] Group Issue Statement, Case No. 23-0397GC.

of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-2).[5]

Medicare Contractor's Contentions: Issue 1 – SSI Percentage (Provider Specific)

The Medicare Contractor argues that the Board lacks jurisdiction over the SSI Percentage (Provider Specific) issue, which "has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment."[6] The Medicare Contractor contends that the portion of the issue related to "individuals who are eligible for SSI but did not receive SSI payment should be dismissed, as it is duplicat[ive]" of the issue in CIRP Group, Case No. 23-0397GC.[7] With regard to the portion of the issue related to SSI realignment, the Medicare Contractor argues this component should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[8] Finally, the Medicare Contractor asserts that the Provider failed to file a complete PPP with a fully developed narrative, including all exhibits, or alternatively, explain its efforts to obtain documents which are missing in accordance with Board Rule 25.2.2. For these reasons, the Medicare Contractor requests dismissal of the SSI Percentage Provider Specific) issue.[9]

Provider's Jurisdictional Response: Issue 1- SSI Percentage (Provider Specific)

Board Rule 44.4.3 specifies: "[p]roviders must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."[10] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so elapsed on November 6, 2024.

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby ***dismisses*** the Provider's Issue No. 1, SSI Provider Specific.

A. SSI Percentage (Provider Specific)

The analysis for Issue No. 1 has three relevant aspects to consider: (1) individuals who are

[5] Provider's PPP at 7-8.
[6] Medicare Contractor's Jurisdictional Challenge ("JC") at 1 (Oct. 7, 2024).
[7] *Id.* at 4.
[8] *Id.* at 5-6.
[9] *Id.* at 6-10.
[10] Board Rules v. 3.2 (Dec. 2023).

eligible for SSI but did not receive SSI payment; (2) data accuracy and (3) SSI realignment.

1. First Aspect of Issue 1

The aspect of Issue No. 1 related to the Provider's disagreement with how the MAC computed the SSI percentage because of CMS' policy of excluding patients that were entitled to SSI from the numerator of the Medicare fraction—is duplicative of the Unduly Narrow Definition of SSI Entitlement issue that is being pursued in the "BJC Healthcare CY 2019 DSH SSI Unduly Narrow Definition of SSI Entitlement CIRP Group," Case No. 23-0397GC.

In its individual appeal, the Provider argues that CMS inconsistently interprets the term "entitled" as used in the statute because it requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. "CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment."[11] This issue disputing CMS's policy concerning individuals who are eligible for SSI but did not receive SSI payment, is the same issue under appeal in the CIRP group, Case No. 23-0397GC, in which the Provider is a participant. Because this aspect of the issue related to the term "entitled" in Case No. 24-0494 is duplicative of the Unduly Narrow issue described in the CIRP Group, Case No. 23-0397GC and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this aspect of the SSI - Provider Specific issue.

2. *Second Aspect of Issue 1*

With regard to the data accuracy component of the issue, the Board finds that the Provider's PPP failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** available documentation necessary to provide a thorough understanding of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of any alleged "errors" in its PPP and include *all* exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents (Dec. 2023)**
>
> If documents necessary to support your position are still unavailable, the provider the following information in the position papers:

[11] Issue Statement at 1.

1. *Identify* the missing documents;
2. *Explain why* the documents remain unavailable;
3. *State the efforts* made to obtain the documents; *and*
4. *Explain when* the documents will be available.

Once the documents become available, promptly forward them to the Board and the opposing party.[12]

The Provider only cites to the 2000 Federal Register in its PPP, but additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule:

> [b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MEDPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year.[13]

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[14]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not

[12] (Italics and underline emphasis added.)
[13] 70 Fed. Reg. 47278, 47438 (Aug. 12, 2005) (bold and italics emphasis added).
[14] Last updated Sept. 28, 2026.

explain what information it needs or is waiting for, nor does it identify the claims to which it should have access or why this is not a common issue already covered by the CIRP group under Case No. 23-0397GC.

Additionally, the Provider's PPP states, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra [sic] (Appellants' reply brief included as Exhibit P-2)."[15] The Board finds that this incorporation by reference does not comply with the regulatory and Board Rule requirements to *fully* develop the Provider's position in the PPP. Particularly 42 C.F.R. § 405.1853 provides, in pertinent part:

> (b)(2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[16]

An incorporation of arguments by reference from a different case simply fails to do so.

3. Third Aspect of Issue 1

The third aspect of the SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Moreover, without this written request, the MAC cannot issue a final determination with which the Provider can be dissatisfied for Board appeal purposes. There is nothing in the record to indicate the MAC has made a final determination regarding DSH SSI Percentage realignment.

Further, the Board finds that the Provider did not brief this issue within its PPP. Board Rule Rule 25.3 addresses issues that are not briefed in a provider's PP. In relevant part, this rule states: "If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn."

Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

****

[15] Provider's PPP at 7-8.
[16] (Emphasis added).

Based on the foregoing, the Board is dismissing the last remaining issue in this case: DSH Payment SSI Percentage (Provider Specific) - Issue No. 1. As no issues remain, the Board hereby closes Case No. 24-0494 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.
Clayton J. Nix, Esq.

For the Board:

9/28/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: KEVIN D. SMITH -A

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson C. Leong, Esq., Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Board Dismissal***
Memorial Hospital of Salem County (Provider Number 31-0091)
FYE: 1/31/2019
Case Number: 23-0052

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the documentation in the above referenced appeal. The decision of the Board is set forth below.

Background:

A. *Procedural History for Case No. 23-0052*

On **April 21, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year ended January 30, 2019.

On **October 10, 2022**, the Board received the Provider's individual appeal request. The Appeal Request was filed by the parent organization, Community Health Systems, Inc. ("CHS") and included five (5) issues:

1. DSH Pymt/SSI % (Provider Specific)
2. DSH Pymt/SSI % (Systemic Errors)[1]
3. DSH Pymt - Medicaid Eligible Days[2]
4. Medicare Managed Care Part C Days – SSI & Medicaid Fraction[3]
5. Dual Eligible Days ("DE days") – SSI & Medicaid Fraction[4]

[1] On May 30, 2023, this issue was transferred to Case No. 22-1031GC.
[2] On September 22, 2026, this issue was withdrawn.
[3] On May 30, 2023, this issue was transferred to Case No. 23-0078GC.
[4] On May 18, 2023, CHS requested the DE days issue be bifurcated. On May 30, 2023, prior to the Board rendering a decision on the bifurcation request, CHS transferred the combined SSI/Medicaid Fraction DE days issue was transferred to an SSI Fraction DE days group under Case No. 23-0080GC. Consequently, on June 26, 2023 the Board denied the bifurcation. The Board found that by transferring the combined SSI/Medicaid fraction DE issue to the SSI Fraction DE days group, the Provider had abandoned the Medicaid fraction DE days issue.

On **October 13, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers ("PPP").[5] This Notice also gave the following instructions to the Provider regarding the content of its PPP:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[6]

On **June 5, 2023**, CHS timely filed the Provider's PPP.

On **August 8, 2023**, the Medicare Contractor filed a Jurisdictional Challenge.[7]

On August 10, 2023, CHS requested the representative be changed to Quality Reimbursement Services, Inc. ("QRS") which the Board acknowledged on the same day.

On **September 6, 2023**, the Medicare Contractor filed its PPP.

On **March 30, 2026**, the Board issued a Notice of Hearing scheduling the case for a **December 21, 2026** hearing**.**

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 22-1031GC

In its Individual Appeal Request, the Provider summarizes its SSI (Provider Specific) issue as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.

[5] On March 16, 2023 the Board issued an updated Critical Due Dates notice.
[6] (Bold, italics, and underline emphasis added.)
[7] The MAC's challenge was over the SSI Provider Specific and Medicaid Eligible Days issue. Since the Medicaid Eligible Days issue was withdrawn, only the SSI Provider Specific arguments will be addressed.

> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[8]

The group issue statement in Case No. 22-1031GC, CHS CY 2019 DSH SSI Percentage CIRP Group, to which the Provider transferred Issue 2 reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

[8] Issue Statement at 1.

The Providers challenge their SSI percentages based on the following reasons:

1. Availability of MEDPAR and SSA records,
2. Paid days vs. Eligible days,
3. Not in agreement with provider's records,
4. Fundamental problems in the SSI percentage calculation,
5. Covered days vs. Total days and
6. Failure to adhere to required notice and comment rulemaking procedures.

COVERED DAYS VS. TOTAL DAYS

The statutory language defines the Medicare/SSI fraction as consisting solely of days for patients who were "entitled to benefits under part A" of Medicare. The numerator includes only those Part A days for patients who are also entitled to SSI benefits. The denominator of the Medicare/SSI fraction includes all Part A days. As set forth in the statutory language above, the numerator of the Medicaid fraction consists of days of patients who were both eligible for medical assistance under Title XIX, or Medicaid, and not entitled to benefits under Part A of Title XVII, or Medicare. The denominator for the Medicaid fraction is the hospital's total patient days for the period.

CMS considers an individual to be "entitled to benefits under Part A" regardless of whether the days were "covered" or paid by Medicare. This means that now Part C days, Exhausted Benefit days, and Medicare Secondary Payer ("MSP") days are included in the denominator of the Medicare/SSI fraction even when there is no payment by Medicare, which is a departure from the treatment of these days as excluded from the Medicare/SSI fraction prior to the 2004 rule.

The Provider(s) contend(s) that if CMS includes unpaid Medicare Part A days in the denominator of the Medicare/SSI fraction, then unpaid SSI eligible patient days must be included in the numerator of the Medicare/SSI fraction, utilizing SSI payment codes that reflect the individuals' eligibility for SSI – even if the individuals did not receive SSI payments, as a matter of statutory consistency.[9]

The amount in controversy listed for Issues 1 and 2 in the Provider's individual appeal request is $24,288, for each issue.

[9] Group Appeal Issue Statement in Case No. 22-1031GC.

On June 5, 2023, the Provider filed its PPP in Case No. 23-0052. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Issue #1: Provider Specific**
>
> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' [*sic*] SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[10]

Medicare Contractor's Contentions Issue 1 – DSH Payment/ SSI Percentage (Provider Specific):

In its jurisdictional challenge, the Medicare Contractor argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue, which has "three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment."[11] The Medicare Contractor contends that "the first and third sub-issues should be dismissed because they are duplicative" of the SSI Systemic Errors issue under appeal in Group Case 22-1031GC. The Medicare Contractor also contends that the component related to SSI realignment should be dismissed "because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies."[12] Finally,

[10] Provider's Preliminary Position Paper at 8-9 (June 5, 2023).
[11] Medicare Contractor's Jurisdictional Challenge ("JC") at 2 (Aug. 8, 2023).
[12] *Id.*

the Medicare Contractor asserts that the Provider did not file a complete preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3.[13]

Provider's Jurisdictional Response:

Board Rule 44.4.3 specifies: "[p]roviders must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."[14] The Provider did not file a response to the Jurisdictional Challenge and the time for doing so elapsed on September 27, 2023.

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby ***dismisses*** the Provider's Issue No. 1, SSI Provider Specific.

The analysis for Issue No. 1 has three relevant aspects to consider: (1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, (2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period, and (3) individuals who are eligible for SSI but did not receive SSI payment.

1. *First and Third Aspects of Issue 1*

The first and third aspects of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage and the individuals who are eligible for SSI but did not receive SSI payment—are duplicative of the DSH/SSI Percentage (Systemic Errors) issue that is being appealed in Case No. 22-1031GC.

The SSI (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[15] Per the appeal request, the Provider's legal basis for its SSI (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[16] The Provider argues in its issue statement that it "disagrees

[13] *Id.* at 9.
[14] Board Rules v. 3.1 (Nov. 2021).
[15] Issue Statement at 1.
[16] *Id.*

with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[17]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in Group Case No. 22-1031GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the SSI (Provider Specific) issue is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 22-1031GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6,[18] the Board dismisses this aspect of the SSI (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[19] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors are specific to this provider.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 22-1031GC but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's PPP failed to comply with Board Rule 25 (Nov. 2021) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Nov. 2021), the Board requires position papers "to be ***fully*** developed and include ***all*** available documentation necessary to provide a thorough understanding of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of any alleged "errors" and include *all* exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents (Nov. 2021)**
>
> If documents necessary to support your position are still unavailable, the provide the following information in the position papers:

[17] *Id.*
[18] Board Rules v. 3.1 (Nov. 2021).
[19] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

> 1. *Identify* the missing documents;
> 2. *Explain why* the documents remain unavailable;
> 3. *State the efforts* made to obtain the documents; *and*
> 4. *Explain when* the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[20]

The Provider only cites to the 2000 Federal Register in its PPP, but additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule,

> [b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year.[21]

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[22]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not

[20] (Italics and underline emphasis added.)
[21] 70 Fed. Reg. 47278, 47438 (Aug. 12, 2005) (bold and italics emphasis added).
[22] Last updated Sept. 28, 2026.

explain what information it needs or is waiting for, nor does it identify the claims to which it should have access or why this is not a common issue already covered by the CIRP group under Case No. 22-1031GC.

Additionally, the Provider's PPP states, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra [sic] (Appellants' reply brief included as Exhibit P-3)."[23] The Board finds that this incorporation by reference does not comply with the regulatory and Board Rule requirements to *fully* develop the Provider's position in the PPP. Particularly 42 C.F.R. § 405.1853 provides, in pertinent part:

> (b)(2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[24]

An incorporation of arguments by reference from a different case simply fails to do so.

Accordingly, *based on the record before it*, the Board finds that the SSI (Provider Specific) issue in Issue 1 and the group issue from the CHS CIRP group under Case No. 22-1031GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the SSI (Provider Specific) issue. Additionally, the failure to fully develop its case in the PPP would serve as a separate reason to dismiss this component of the issue.

2. Second Aspect of Issue 1

The second aspect of the SSI (Provider Specific) issue - the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is also dismissed by the Board. Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board dismisses this aspect of the appeal.

* * * * *

[23] Provider's PPP at 8-9.
[24] (Emphasis added).

Based on the foregoing, the Board has dismissed the remaining issue in this case in its entirety. As no issues remain, the Board hereby closes Case No. 23-0052 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.
Clayton J. Nix, Esq.

For the Board:

9/28/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: KEVIN D. SMITH -A

cc: Wilson C. Leong, Esq., Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran, President
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RE: ***Board Decision – Dismissal of SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues***
Southampton Memorial Hospital (Prov. No. 49-0092), FYE 12/31/2018
Case No. 23-1344

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-1344. Set forth below is the background of the case and the Board's decision related to the issues challenging the SSI-Provider Specific and Medicaid Eligible Days issues.

Background:

A. ***Procedural History for Case No. 23-1344***

On **November 3, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2018.

On **April 21, 2023**, Community Health Systems ("CHS") filed an appeal on behalf of the Provider. The Appeal Request included five (5) issues:

1. DSH Pymt/SSI % (Provider Specific)
2. DSH/SSI - Unduly Narrow Definition of SSI Entitlement[1]
3. DSH Pymt - Medicaid Eligible Days
4. Medicare Managed Care Part C - SSI & Medicaid Fractions[2]
5. Dual Eligible Days - SSI and Medicaid Fractions[3]

The Provider is commonly owned by CHS, so it is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1).

On **April 21, 2023**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates ("ACDD"), providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter* "PPP".) This Notice also gave the following instructions to the Provider regarding the content of its PPP:

[1] On November 21, 2023, CHS transferred this issue to an SSI Systemic Errors CIRP Group, Case No. 21-1206GC. On August 7, 2026, the Board subsequently denied the transfer because it determined the issues were not the same. On August 8, 2026, QRS transferred the issue to a new Unduly Narrow CIRP group under Case No. 26-2711GC.
[2] On November 21, 2023, this issue was transferred to Case No. 20-2149GC.
[3] On November 21, 2023, this issue was transferred to Case No. 21-0066GC.

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[4]

On **December 18, 2023**, CHS filed the Provider's PPP and on **March 6, 2024** the Medicare Contractor filed its PPP.

On **March 21, 2024**, the MAC filed a jurisdictional challenge.

On **August 10, 2026,** CHS filed a change in representation to Quality Reimbursement Services, Inc. ("QRS") which the Board acknowledged the same day.

B. Description of Issue 1 in the Appeal Request

In its Individual Appeal Request, the Provider summarizes its SSI Percentage (Provider Specific) issue as follows:

> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator'. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[5]

[4] (Emphasis added.)
[5] Issue Statement at 1.

On December 18, 2023, the Board received the Provider's PPP in Case No. 23-1344. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of *Advocate Christ Medical Center, et al, v Xavier Becerra* (Appellants' reply brief included as Exhibit P-3).[6]

The amount in controversy listed for both Issue 1 and Issue 2 in the Provider's individual appeal request is $7,154.

Description of Issue 3 in the Appeal Request

In its Individual Appeal Request, the Provider questions whether the MAC properly excluded Medicaid eligible days from the DSH calculation. The Statement of the Legal Basis is as follows:

> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.

[6] Provider's PPP at 7-8.

The estimated reimbursement amount for this issue is $34,453.[7]

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[8] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[9]

The Provider then, for the first time in this appeal, states it is seeking reimbursement for section 1115 waiver days as a part of the Medicaid eligible day issue. Specifically, the Provider states:

> [M]edicaid eligible days (including section 1115 waiver days (where applicable), which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its 2018 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[10]

MAC's Contentions: Issue 1 – DSH SSI Provider Specific

In its jurisdictional challenge, the MAC argues that the Board lacks jurisdiction over the SSI- Provider Specific issue, which has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of the issue under appeal in the CIRP group. The component related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies. Finally, the MAC asserts the SSI Provider Specific issue should be dismissed because the Provider did not file a complete PPP in accordance with 42 C.F.R. § 405.1853 and Board Rule 25.[11]

MAC's Contentions: Issue 3 – DSH Medicaid Eligible Days

The MAC also argues the Board lacks jurisdiction over the Medicaid Eligible Days issue. The MAC contends that the Provider failed to include a list of additional Medicaid eligible days they expect to be included with their appeal or their PPP, even though the Provider advised that it would send a listing

[7] Issue Statement at 3.
[8] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[9] Provider's PPP at 8.
[10] *Id.* at 8-9.
[11] MAC Jurisdiction Challenge at 2.

of additional Medicaid eligible days under separate cover, and even after the MAC sent the Provider a request for the information. In addition, the MAC challenges the Provider's attempt to improperly and untimely add the Section 1115 Waiver Days issue by including it in the narrative of the PPP.[12]

Provider's Jurisdictional Response

Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."[13] The Provider failed to file a timely response by the *April 20, 2024* deadline.

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby dismisses the Provider's Issue Nos. 1 and 3.

A. SSI Percentage (Provider Specific)

The analysis for Issue No. 1 has three relevant aspects to consider: (1) individuals who are eligible for SSI but did not receive SSI payment; (2) data accuracy and (3) SSI realignment.

1. First Aspect of Issue 1

The aspect of Issue No. 1 related to the Provider's disagreement with how the MAC computed the SSI percentage because of CMS' policy of excluding patients that were entitled to SSI from the numerator of the Medicare fraction—is duplicative of the Unduly Narrow Definition of SSI Entitlement issue that is being pursued as Issue #2.

The SSI - Provider Specific issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[14] Per the appeal request, the Provider's legal basis for its SSI Percentage (Provider Specific) issue asserts that the MAC "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[15] The Provider argues that "its'[sic] SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[16] Finally, the Provider argues that CMS

[12] *Id.* at 10, 13.
[13] PRRB Rules v. 3.1 (Nov. 2021).
[14] Issue Statement at 1.
[15] *Id.*
[16] *Id.*

inconsistently interprets the term "entitled" as used in the statute because it requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. "CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment." These arguments are restated in Issue No. 2 where the Provider points to CMS' policy of applying different interpretations to the term "entitled."[17]

The Board finds that aspect of the issue related to the term "entitled" in Case No. 23-1344 is duplicative of the Unduly Narrow issue described at Issue No. 2, which was subsequently transferred to a CIRP group, Case No. 26-2711GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[18], the Board dismisses this aspect of the SSI - Provider Specific issue.

2. Second Aspect of Issue 1

With regard to the data accuracy aspect of the issue, the Board finds that the Provider's PPP failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of any alleged "errors" in its PPP and include *all* exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents[19]**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[20]

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule:

> Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MEDPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the

[17] Issue Statement at 2.
[18] PRRB Rules v. 3.1 (Nov. 2021).
[19] PRRB Rules v. 3.1 (Nov. 2021)
[20] (Italics and underline emphasis added.)

> hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[21]

Additionally, in its PPP, the Provider states, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra [sic] (Appellants' reply brief included as Exhibit P-3)." The Board finds that this incorporation by reference does not comply with the regulatory and Board rule requirements to *fully* develop the Provider's position in the PPP. Particularly 42 C.F.R. § 405.1853 provides in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[22]

An incorporation of arguments by reference from a different case simply fails to do so. Accordingly, the Board dismisses that portion of the issue as well.

3. Third Aspect of Issue 1

The aspect of the SSI Percentage (Provider Specific) issue related to the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period is also dismissed by the Board.

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Moreover, without this written request, the MAC cannot issue a final determination with which the Provider can be dissatisfied

[21] Last updated July 31, 2026.
[22] (Emphasis added).

for Board appeal purposes. There is nothing in the record to indicate the MAC has made a final determination regarding DSH SSI Percentage realignment. In accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses the Realignment aspect of the appeal.

B. DSH Payment – Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider's issue statement for Issue 3 is stated, *supra*.

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days that affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii), which places the burden of production on the provider states in pertinent part:

> The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) states:

> The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

Furthermore, 42 C.F.R. § 405.1853 addresses position papers and specifies in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.

> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[23]

Similarly, Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[24] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides instruction on the content of position papers as it relates to unavailable documentation/exhibits, as discussed *supra*.

Relative to a Medicaid Eligible Days determination, it is well-established that adequate data to prove eligibility for each Medicaid patient day claimed is a complete and accurate (i.e., auditable) Medicaid eligible days listing, which upon timely submission by a provider, a MAC can examine to make applicable adjustments.

This appeal was initiated on April 21, 2023 (more than 3.5 years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expect to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Provider's PPP indicated that it would be sending the eligibility listing under separate cover.[25] ***To-date, the MAC has not been provided an auditable listing.*** Accordingly, the Provider has abandoned the issue by failing to properly develop its arguments and provide supporting documents, and by failing to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[26] Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.

C. 1115 Waiver Days

The Board finds that the Section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the Section 1115 Waiver days.

The regulations in effect when this appeal was filed with the Board in April of 2023 required the following:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be

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[23] (Emphasis added).
[24] (Emphasis added).
[25] Provider's PPP at 9.
[26] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

> submitted in writing in the manner prescribed by the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.[27]

Board Rule 7.2.1 elaborated on this regulatory requirement, instructing providers:

The following information and supporting documentation must be submitted for each issue raised in the appeal request.

- An issue title and a concise issue statement describing:
  - the relevant adjustment(s), including the adjustment number(s),
  - the controlling authority (*e.g.*, specific regulation, Federal Register issuance, manual provision, or Ruling),
  - why the adjustment(s) is incorrect,
  - how the payment should be determined differently,
  - the reimbursement effect, and
  - the basis for jurisdiction before the Board.

Board Rule 8 explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these examples are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[28]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[29]

[27] 42 C.F.R. § 405.1835(b).
[28] (Bold and italic emphasis added).
[29] *See* 73 Fed. Reg. 30190 (May 23, 2008).

42 C.F.R. § 405.1835(e) provides in relevant part:

> (e) Adding issues to the hearing request. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
> . . .
>
> (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

In practice, this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider added the Section 1115 Waiver days to the case properly or timely.

In this regard, the Board notes that Section 1115 Waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[30] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program and not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) states in pertinent part:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.**

[30] 65 FR 47054, 47087 (Aug. 1, 2000).

> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for **each** Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Because the Provider did not raise the Section 1115 Waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The DSH Medicaid Eligible Days issue as stated in the original appeal request cannot be construed to include Section 1115 Waiver days. Additionally, there is no indication that any 1115 Waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

Regardless, even if the Provider had included in its appeal request (***which it did not***), the Provider failed to properly develop the issue in its PPP filing as it does not identify the specific 1115 waiver day program(s) at issue). In addition, the PPP does not discuss whether or not the Section 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the PPP is perfunctory in that it only makes cursory conclusions.[31] Again, the Provider failed to develop its PPP, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 23 (Nov. 2021).

As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* Section 1115 waiver days sub-issue.

The Board's finding that neither the appeal request nor the PPP met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[32] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[33] The Court found that "[t]his description does not specify

[31] For example, CHS cites to *Forrest General Hosp.*, 926 F.3d 221 (5th Cir. 2019) for the proposition that "the plain language of the statute and regulations require inclusion in the Medicaid Fraction of the days belong to individual who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool." However, CHS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is CHS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? CHS fails to brief the merits of its claims and fails to establish the Board's jurisdiction over the § 1115 waiver day issue as required by 42 C.F.R. § 405.1853(b)(2). Indeed, the quoted sentence is the only time the PPP references "uncompensated care pool."

[32] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

[33] *Id*. at *11.

which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[34] The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[35] Here, the Board makes the same finding based on similarly *overly generalized language.*

****

Based on the foregoing, the Board is dismissing the SSI - Provider Specific - Issue No.1 and Medicaid Eligible Days (*including Section 1115 Waiver Days*) - Issue No. 3 from this case.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.
Clayton J. Nix, Esq.

For the Board:

9/28/2026

X Nicole E. Musgrave

Nicole E. Musgrave, Esq.
Board Member
Signed by: Nicole Musgrave-burdette -S

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson C. Leong, Esq., Federal Specialized Services

[34] *Id.*
[35] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran, President
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Notice of Dismissal***
Northwest Medical Center (Prov. No. 03-0085), FYE 09/30/2021
Case No. 25-6009

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 25-6009. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 25-6009*

On **April 23, 2025**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2021.

On **September 25, 2025**, the Board received the Provider's individual appeal request. The Appeal Request was filed by Community Health Systems, Inc. ("CHS") and included six (6) issues:

1. DSH Pymt/SSI % (Provider Specific)[1]
2. DSH SSI -Unduly Narrow Definition of SSI Entitlement[2]
3. DSH Pymt - Medicaid Eligible Days
4. Medicare Managed Care Part C – SSI & Medicaid Fractions[3]
5. Improper Rulemaking – SSI Fraction Dual Eligible Days[4]
6. Improper Rulemaking – Medicaid Fraction Dual Eligible Days[5]

The Provider is commonly owned by CHS, so it is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1).

[1] On May 19, 2026, this issue was withdrawn.
[2] On April 9, 2026, this issue was transferred to Case No. 26-2198GC
[3] On April 6, 2026, this issue was transferred to Case No. 24-1834GC.
[4] On April 6, 2026, this issue was transferred to Case No. 24-1835GC.
[5] On April 6, 2026, this issue was transferred to Case No. 24-1836GC.

On **September 25, 2025**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers (hereinafter "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[6]

On **February 17, 2026**, the MAC uploaded a copy of its Request to the Provider for DSH (ME Days) Package.

On **April 8, 2026,** CHS requested a change of representation to Quality Reimbursement Services, Inc. ("QRS") which the Board acknowledged on April 9. 2026.

On **May 22 2026**, QRS filed the Provider's PPP.

On **July 21, 2026**, the MAC filed a Jurisdictional Challenge.

On **August 14, 2026,** the MAC filed its PPP.

B. ***Description of Issue 3 in the Appeal Request***

In its Individual Appeal Request, the Provider questions whether the MAC properly excluded Medicaid eligible days from the DSH calculation. The Statement of the Legal Basis is as follows:

> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.

[6] (Emphasis added.)

The estimated reimbursement impact for the issue is $145,456.[7]

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[8] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[9] The Provider's briefing of the issue is as follows:

> **Calculation of Medicaid Eligible Days**
>
> The Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.

[7] Issue Statement at 3.
[8] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[9] Provider's PPP at 8.

Then for the first time, the Provider mentions the Section 1115 Waiver days issue:

> Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover directly to the MAC, including Section 1115 waiver days (a redacted copy is attached), the Provider contends that the total number of days reflected in its 2021 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.
>
> With respect to section 1115 waiver days, the courts have firmly rejected CMS's interpretation of its regulations, holding instead that the plain language of the statute and the regulations require inclusion in the Medicaid Fraction of the days belonging to individuals who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool. *See Forrest General Hospital*, 926 F.3d 221 (5th Cir. 2019); *HealthAlliance Hospitals, Inc. v. Azar*, 346 F. Supp. 3d 43(D.D.C. 2018); *Bethesda Health Inc., v. Azar*, 389 F. Supp. 3d 32, (D.D.C. 2019), *aff'd*, 980 F.3d 121 (D.C. Cir. 2020). CMS has acquiesced in *Bethesda* and is now following the statute and the plain meaning of its own regulations (which regulations represent the official policy of CMS all along) and properly accounting for 1115 Waiver days as Medicaid Eligible days. *See* CMS Manual Instructions System, Change Request 12669, Transmittal No. 11912 (March 16, 2023) ("Transmittal 11912"), attached as Exhibit P-3.[10]

MAC's Contentions- DSH – Medicaid Eligible Days

The MAC contends that the Provider failed to include a list of additional Medicaid eligible days they expect to be included with their appeal or their PPP, even though the Provider advised that it would send a listing of additional Medicaid eligible days under separate cover. The Medicaid Eligible Days issue has been abandoned because of the Provider's failure to properly develop its

[10] *Id*. at 9-10.

arguments or provide the necessary supporting documents or explain why it cannot produce those documents in accordance with the regulations and Board Rules.[11]

The MAC also challenges the Provider's attempt to untimely add the Section 1115 Waiver Days issue by including it in the narrative of the PPP.[12] Additionally, the MAC contends the 1115 Waiver days issue is a separate and distinct issue.[13]

Provider's Jurisdictional Response

Board Rule 44.4.3 requires that: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so elapsed on August 20, 2026.

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby ***dismisses*** the Provider's sole remaining issue.

A. DSH Payment – Medicaid Eligible Days

The Provider did not include a list of the specific additional Medicaid eligible days that are in dispute in the initial appeal.

With regard to the filing of an individual appeal, Board Rule 7 - Support for Appealed Final Determination, Availability of Issue-Related Information and Basis for Dissatisfaction (Dec. 2023) states:

> **No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

[11] MAC's Jurisdictional Challenge at 2.
[12] *Id.* at 7.
[13] *Id*. at 10.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[14]

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Board Rule 25 (Dec. 2023) requires the Provider to file its complete, *fully* developed PPP with all available documentation and gives the following instruction on the content of position papers:

Rule 25 - Preliminary Position Papers[15]

> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the following sub-sections.

[14] (Bold emphasis added.)
[15] (Underline emphasis added to these excerpts and all other emphasis in original.)

25.1.1 The Provider's Position Paper

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
D. Provide a conclusion applying the material facts to the controlling authorities.

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to the Board

Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R.

> § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The September 25, 2025 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with the Medicaid Eligible Days issue, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[16]

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has reasonable basis to believe that the issues have been fully settled or abandoned,

[16] (Emphasis added.)

- upon failure of the provider or group to comply with Board procedures (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On May 22, 2026, the Provider filed its PPP in which it indicated that the eligibility listing was imminent by promising that the listing was being sent to the MAC under separate cover.[17] The Provider's briefing of this issue in its PPP is stated *supra*.

In its July 21, 2026 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid Eligible days issue because the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable) with its appeal request or its PPP in violation of 42 C.F.R. §405.1853 and Board Rule 25.3. Thus, the MAC asserts that the Provider has essentially abandoned the issue.[18] In addition, the MAC indicated the Provider attempted to untimely and improperly add the issue of Section 1115 waiver days by including the issue in its PPP. The MAC pointed out that, although the waiver days issue is a component of the Medicaid Eligible days issue, it is considered a separate and distinct issue.

The Board concurs with the MAC that the Provider is required to identify *the material facts* (*i.e.*, the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(4)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Provider failed to fully develop the merits of the Medicaid Eligible days issue because it failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue.

The Board finds that the Provider has essentially abandoned the Medicaid Eligible days issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.

B. Section 1115 Waiver Days

The Board also concurs with the MAC, that the Section 1115 waiver days issue is not a part of this appeal as it was not properly or timely added. While the Provider appealed Medicaid Eligible days, this issue is separate and distinct from the Section 1115 waiver days.

---

[17] Provider's PPP at 9.

[18] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

The appeal was filed with the Board in September of 2025 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[19]

Board Rule 7.2.1 elaborated on this regulatory requirement, instructing providers:

> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
>   - the adjustment, including the adjustment number,
>   - the controlling authority,
>   - why the adjustment is incorrect,
>   - how the payment should be determined differently,
>   - the reimbursement effect, and
>   - the basis for jurisdiction before the [Board].

Board Rule 8 explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**

[19] 42 C.F.R. § 405.1835(b).

> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[20]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[21]

42 C.F.R. § 405.1835(e) provides in relevant part:

> (e) Adding issues to the hearing request. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
> . . .
> (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

In practice, this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider properly or timely added the Section 1115 waiver days issue to the case.

In this regard, the Board notes that Section 1115 waiver days are not traditional Medicaid Eligible days and, indeed, were only incorporated into the DSH calculation effective January 20, 2000.[22] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 waiver days. Indeed, not every state Medicaid program has a qualifying Section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a Section 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) (2019) states in pertinent part:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient

[20] (Bold and italic emphasis added).
[21] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[22] 65 FR 47054, 47087 (Aug. 1, 2000).

> hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.**
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for **each** Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Because the Provider did not raise the Section 1115 waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The Medicaid Eligible days issue as stated in the original appeal request cannot be construed to include Section 1115 waiver days. Additionally, there is no indication that any Section 1115 Waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

Regardless, even if the Provider had included in its appeal request (***which it did not***), the Provider failed to properly develop the issue in its PPP filing as it does not identify the specific 1115 waiver day program(s) at issue). In addition, the PPP does not discuss whether or not the Section 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the PPP is perfunctory in that it only makes cursory conclusions.[23] Again, the Provider failed to so develop its PPP, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 23 (Dec. 2023).

As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each

[23] For example, CHS cites to *Forrest General Hosp.*, 926 F.3d 221 (5th Cir. 2019) for the proposition that "the plain language of the statute and regulations require inclusion in the Medicaid Fraction of the days belong to individual who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool." However, CHS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is CHS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? CHS fails to brief the merits of its claims and fails to establish the Board's jurisdiction over the § 1115 waiver day issue as required by 42 C.F.R. § 405.1853(b)(2). Indeed, the quoted sentence is the only time the PPP references "uncompensated care pool."

claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* Section 1115 waiver days sub-issue.

The Board's finding that neither the appeal request nor the PPP met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[24] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[25] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[26] The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[27] Here, the Board makes the same finding based on similar *overly generalized language.*

* * * * *

Based on the foregoing, the Board dismisses the sole remaining issue in this case – Medicaid Eligible days (including Section 1115 waiver days.) As no issues remain, the Board hereby closes Case No. 25-6009 and removes it from the Board's docket.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
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For the Board:

9/29/2026

X Nicole E. Musgrave

Nicole E. Musgrave, Esq.
Board Member
Signed by: Nicole Musgrave-burdette -S

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson Leong, FSS

[24] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[25] *Id*. at *11.
[26] *Id.*
[27] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran, President
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Notice of Dismissal***
Bluefield Regional Medical Center (Prov. No. 50-0071), FYE 06/30/2018
Case No. 25-1769

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 25-1769. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Medicaid Eligible Days issue.

Background:

A. ***Procedural History for Case No. 25-1769***

On **August 19, 2024**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2018.

On **January 28, 2025**, the Board received the Provider's individual appeal request. The Appeal Request was filed by the parent organization, Community Health Systems, Inc. (hereinafter "CHS") and included five (5) issues:

1. DSH Pymt/SSI % (Provider Specific)[1]
2. DSH Pymt - Medicaid Eligible Days
3. Medicare Managed Care Part C Days – SSI & Medicaid Fraction[2]
4. Improper Rulemaking – SSI Dual Eligible Days[3]
5. Improper Rulemaking – Medicaid Fraction Dual Eligible Days[4]

Since the Provider is commonly owned by CHS, it is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1).

[1] On December 17, 2025, this issue was withdrawn.
[2] On August 8, 2025, this issue was transferred to Case No. 20-2149GC.
[3] On August 8, 2025, this issue was transferred to Case No. 21-0078GC.
[4] On August 8, 2025, this issue was transferred to Case No. 21-0066GC.

On **January 29, 2025**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter*, "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[5]

On **September 23, 2025**, CHS filed the Provider's PPP.

On **November 5, 2025**, the MAC filed a Motion to Dismiss.

On **November 11, 2025**, CHS requested a change of representation to Quality Reimbursement Services, Inc. ("QRS") which the Board acknowledged the following day.

On **December 15, 2025**, the MAC filed its PPP.

On **December 15, 2025**, QRS filed a *late* response to the MAC's Motion to Dismiss.

B. ***Description of Issue 2 in the Individual Appeal Request***

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations. The Provider describes Issue 2 as:

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the

[5] (Emphasis added.)

> Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.

The estimated reimbursement amount is $35,461.

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[6] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[7]

MAC's Contentions: Issue 2 – DSH Payment – Medicaid Eligible Days

The MAC filed a Motion to Dismiss in which it argued the Board should dismiss the Medicaid Eligible Days issue. The MAC contends that the Provider failed to include an auditable list of additional Medicaid eligible days they expect to be included with their appeal or their PPP, even though the Provider advised that it would send a listing of additional Medicaid eligible days under separate cover and even though the MAC requested one on October 27, 2025.[8] Thus, the Provider has failed to furnish documentation in support of its claim or describe why such documentation is unavailable per Board Rules 7. 25.2.1 and 25.2.2. The MAC contends the Provider has abandoned this issue.[9]

Provider's Jurisdictional Response – Medicaid Eligible Days

Board Rule 44.3 specifies: "Unless the Board imposes a different deadline, an opposing party may file a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."[10] The Provider did not file a timely response to the Motion to Dismiss. The time for doing so elapsed on *December 5, 2025*.[11]

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[6] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[7] Provider's PPP at 8.
[8] MAC's Motion to Dismiss at 3.
[9] MAC's Motion to Dismiss at 7.
[10] Board Rule 44.3, v. 3.2 (Dec. 2023).
[11] On December 15, 2023, the Provider filed a late response to the Motion to Dismiss, indicating that "due to unavoidable circumstances, the Provider Representative was not able to complete its additional days listing and send it to the MAC." It contends it sent a listing on December 12, 2025.

Board Analysis and Decision

The Board finds it appropriate to dismiss the DSH Payment – Medicaid Eligible Days issue.

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider's issue statement for Issue 2 is stated, *supra*.

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days that affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii), which places the burden of production on the provider states in pertinent part:

> The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) states:

> The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

Furthermore, 42 C.F.R. § 405.1853 addresses position papers and specifies in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in

> § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[12]

Similarly, with regard to position papers, Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[13] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> **25.2.2 Unavailable and Omitted Documents[14]**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[15]

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's ***own motion***:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned;
- upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868);
- if the Board is unable to contact the provider or representative at the last known address; or
- upon failure to appear for a scheduled hearing.

Relative to a Medicaid Eligible Days determination, it is well-established that adequate data to prove eligibility for each Medicaid patient day claimed is a complete and accurate (i.e., auditable) Medicaid eligible days listing, which upon timely submission by a provider, a MAC can examine to make applicable adjustments.

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[12] (Emphasis added).
[13] (Emphasis added).
[14] PRRB Rules v. 3.2 (Dec. 2023)
[15] (Italics and underline emphasis added.)

This appeal was initiated on January 28, 2025 (more than a year and a half ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expected to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Provider's PPP indicated that it would be sending the eligibility listing to the MAC under separate cover.

In summary, the Board finds that the Provider failed to satisfy the requirements of Board Rules 25.2.1 and 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. Accordingly, the Board finds that the Provider abandoned the Medicaid Eligible days issue by failing to properly develop its arguments and provide supporting documents, and by failing to explain why it did not produce those documents, as required by the regulations and the Board Rules.[16]

****

Based on the foregoing, the Board is dismissing the last remaining issue in this case: "DSH - Medicaid Eligible Days" - Issue 2. As no issues remain, the Board hereby closes Case No. 25-1769 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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Ratina Kelly, CPA
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For the Board:

9/29/2026

X Nicole E. Musgrave

Nicole E. Musgrave, Esq.
Board Member
Signed by: Nicole Musgrave-burdette -S

cc: Dana Johnson, Palmetto GBA c/o Wellpoint Federal Solutions (J-M)
Wilson C. Leong, Esq., Federal Specialized Services

[16] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
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RE: ***Notice of Dismissal***
Alliance Health Ponca City (Prov. No. 37-0006), FYE 05/31/2020, Case No. 24-0535

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 24-0535. Set forth below is the decision of the Board to dismiss the two remaining issues in this appeal: the SSI Provider Specific and Medicaid Eligible Days issues.

Background

A. *Procedural History for Case No. 24-0535*

On **June 28, 2023**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end May 31, 2020.

On **December 19, 2023**, Community Health Systems, Inc. ("CHS") filed the Provider's appeal request. The request included four (4) issues:

1. DSH Pymt/ SSI% (Provider Specific)
2. DSH Pymt - Medicaid Eligible Days
3. Medicare Managed Care Part C Days – SSI & Medicaid Fraction[1]
4. Dual Eligible Days –SSI & Medicaid Fraction[2]

The Provider is commonly owned by CHS so it is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1).

On **October 19, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter* "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

[1] On July 24, 2024, this issue was transferred to Case No. 24-1806GC.
[2] On July 11, 2024, this issue was bifurcated into separate SSI Fraction and Medicaid Fraction Dual Eligible Days issues. The SSI Fraction DE days issue remained at Issue 4 and Issue 5 was created for the Medicaid Fraction DE days issue. On October 2, 2024, CHS transferred these issues to Case Nos. 24-1804GC and 24-1805GC, respectively.

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 25.[3]

On **August 13, 2024**, CHS timely filed the Provider's PPP and on **December 11, 2024**, the Medicare Contractor ("MAC") timely filed its PPP.

On **October 22, 2024**, the MAC filed a jurisdictional challenge over the DSH SSI Provider Specific & Medicaid eligible days issues in the case.

On **October 24, 2024**, CHS requested a change of representation to Quality Reimbursement Services, Inc. ("QRS"), which the Board granted on **October 28, 2024**.

B. Description of Issue 1 in the Appeal Request

In its Individual Appeal Request, the Provider summarizes its DSH SSI Provider Specific issue as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed [be]cause CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).[4]

On June 12, 2023, the Board received the Provider's PPP in Case No. 24-0535. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.

[3] (Emphasis added).
[4] Issue Statement at 1.

> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of *Advocate Christ Medical Center, et al, v Xavier Becerra*…. [5]

C. ***Description of Issue 2 in the Appeal Request***

In its Individual Appeal Request, the Provider summarizes its Medicaid eligible days issue as follows:

> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[6]

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[7] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[8]

Then for the first time, the Provider mentions the Section 1115 Waiver days:

---

[5] Provider's PPP at 8-9.
[6] Issue Statement at 2.
[7] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[8] Provider's PPP at 9.

> Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its 2020 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[9]

MAC's Contentions - Issue 1 –SSI Provider Specific

In its Jurisdictional Challenge, the MAC argues that the Board lacks jurisdiction over the DSH – SSI Provider Specific issue which has two components (Data accuracy and SSI Realignment). The MAC argues that the sub-issue related to data accuracy should be dismissed because it was not fully briefed in the PPP in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25. In addition, the MAC maintains that the realignment aspect of the issue should be considered withdrawn as the Provider failed to brief this issue and because there was no final determination over the realignment making the appeal premature as the Provider has not exhausted all available remedies.[10]

MAC's Contentions - Issue 2 – Medicaid Eligible/Section 1115 Waiver Days

In its Jurisdictional Challenge, the MAC advised that the Provider failed to include a list of additional Medicaid eligible days it expected to be included (even though the Provider's PPP included a statement indicating a listing of additional Medicaid eligible days would be sent under separate cover.)[11]

In addition, the MAC challenged jurisdiction over the Section 1115 Waiver Days issue, arguing that the Provider attempted to untimely and improperly add the issue in its PPP, which was beyond the due date to add issues to the case, and that the 1115 Waiver Days is a separate and distinct issue from the Eligible days issue initially appealed.[12]

The MAC also asserted that the Section 1115 waiver days is one component of the DSH issue that must be appealed as a separate issue. The MAC referenced Board Rule 8 which explains that one

[9] Provider's PPP at 9-10.
[10] MAC's Jurisdictional Challenge at 2. *See also* 4 – 8.
[11] *Id.* at 8.
[12] *Id* at 9.

issue can have multiple components. Within Board Rule 8, some of the disproportionate share hospital (DSH) components are identified. Specifically, the Board identifies Section 1115 waiver days as a distinct DSH component that the Provider must appeal separately. [13]

Finally, the MAC contends that the Provider has failed to file a complete PPP in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25."[14]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[15] The Provider failed to file a timely response. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." [16]

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby ***dismisses*** the Provider's SSI Provider Specific and Medicaid Eligible Days issues.

A. SSI Provider Specific

One aspect of the SSI Provider Specific issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[17] Per the appeal request, the Provider's legal basis for its DSH SSI Provider Specific issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[18] In the issue statement filed with the appeal request, the Provider argued, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[19]

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[13] *Id.* at 13.
[14] *Id*. at 14.
[15] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[16] The Provider's Response to the Jurisdictional Challenge was not filed until August 12, 2024, which was almost a year late.
[17] Issue Statement at 1.
[18] *Id.*
[19] *Id.*

The Board finds that the Provider failed to comply with Board Rule 25 governing the content of PPPs, in that the Provider failed to include any evidence to establish the material facts relating to inaccuracies in the SSI Percentage calculation at issue. Therefore, the Provider was in violation of Rule 25.3 because it failed to sufficiently develop the relevant facts and arguments to support its claim.

Moreover, as explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of the any alleged "errors" and include *all* exhibits. Board Rule 25.2.2, requires that the Provider explain the efforts made to obtain any documents which are missing or are unavailable.

Specifically, Board Rule 25.2.2 states:

> **25.2.2 Unavailable and Omitted Documents (Nov. 21, 2021)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[20]

In this case, the Provider fails to explain how it can ascertain from State records, the entitlement of individuals, how that information is relevant, and whether such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2. The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule

> "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data***

[20] (Italics and underline emphasis added.)

> ***set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[21]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on, nor does it discuss the claims to which it should have access.

Additionally, the Provider's PPP states, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra [sic] (Appellants' reply brief included as Exhibit P-3)." The Board finds that this incorporation by reference does not comply with the regulatory and Board rule requirements to *fully* develop the Provider's position in the PPP. Particularly 42 C.F.R. § 405.1853 provides in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[22]

An incorporation of arguments by reference from a different case simply fails to do so. Accordingly, *based on the record before it*,[23] the Board finds that this component of the SSI Provider Specific issue in Case No. 24-0535 has been abandoned.

The other aspect of the SSI Provider Specific issue, related to the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period, is also dismissed by the Board. Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ". Moreover, without this written request, the MAC cannot issue a final determination with which the Provider can be dissatisfied for Board appeal purposes. There is nothing in the

[21] Last modified Sept. 28, 2026.
[22] (Emphasis added).
[23] Again, the Board notes that the Provider failed to timely respond to the Jurisdictional Challenge so the Board must make its determination based on the record before it.

record to indicate the MAC has made a final determination regarding an SSI Percentage realignment. In accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the SSI Provider Specific issue from the appeal.

B. DSH Payment – Medicaid Eligible Days

Medicaid Eligible Days

The Provider did not include a finalized list of the specific additional Medicaid eligible days that are in dispute in this case in either the initial appeal or the PPP.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Dec. 2023) states:

> **No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[24]

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Board Rule 25 (Dec. 2023) requires the Provider to file its complete, *fully* developed PPP with all available documentation and gives the following instruction on the content of position papers:

[24] (Bold emphasis added.)

Rule 25

> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.

Preliminary Position Papers[25]

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the following sub-sections.

25.1.1 The Provider's Position Paper

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
D. Provide a conclusion applying the material facts to the controlling authorities.

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

[25] (Underline emphasis added to these excerpts and all other emphasis in original.)

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to the Board

Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

COMMENTARY: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The January 8, 2024 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 2, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[26]

[26] (Emphasis added.)

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On August 13, 2024, the Provider filed its PPP paper in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.[27] The Provider's briefing of this issue in its PPP is stated *supra*.

In its October 22, 2024 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid Eligible days issue because the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable) with its appeal request or its PPP in violation of 42 CFR §405.1853 and Board Rule 25.3. Thus, the MAC asserts that the Provider has essentially abandoned the issue.[28]

The Board concurs with the MAC that the Provider is required to identify *the material facts* (*i.e.*, the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(4)(iii). After review, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence

[27] Provider's PPP at 10.
[28] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

is unavailable. The Provider failed to fully develop the merits of the Medicaid Eligible days issue because it failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue.

The Board recognizes that the Provider filed a ***redacted*** Eligible Days listing as an exhibit to its PPP, however:

1. An *auditable* version of the 4-page listing filed as Exhibit P-1 was not provided to the MAC;
2. The 4-page *redacted* ME days listing identified 465 'Additional ME Days'; however, no supporting documentation accompanied the exhibit.
3. The Provider did not include an explanation as to why the first time it was filing the ME days listing was more than 4 years after the fiscal year at issue had closed and almost 8 months after the appeal was filed.

The Board finds that the Provider has essentially abandoned the Medicaid Eligible days issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.

Section 1115 Waiver Days

The Board finds that the Section 1115 waiver days issue is not a part of this appeal as it was not included as a cost issue in the appeal, nor was it properly or timely added. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from Section 1115 waiver days.

The appeal was filed with the Board in December of 2023 and the regulations required the following:

> b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) how and why the provider believes Medicare payment must be determined differently for each disputed item…[29]

[29] 42 C.F.R. § 405.1835(b).

Board Rule 7.2.1 elaborated on this regulatory requirement instructing providers:

> The following information and supporting document must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
>   - the adjustment, including the adjustment number,
>   - the controlling authority,
>   - why the adjustment is incorrect,
>   - how the payment should be determined differently,
>   - the reimbursement effect, and
>   - the basis for jurisdiction before the Board.[30]

Board Rule 8 (Dec. 2023) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these examples are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include…***Section 1115 waiver days (program/waiver specific)***[31]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[32] 42 C.F.R. § 405.1835(e) provides in relevant part:

> (c) *Adding issues to the hearing request*. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
> . . .
>
> (2) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

In practice this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider properly or timely added the Section 1115 waiver days issue to the case.

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[30] v. 3.2 (Dec. 2023).
[31] (Bold and italic emphasis added).
[32] *See* 73 Fed. Reg. 30190 (May 23, 2008).

In this regard, the Board notes that Section 1115 waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[33] Rather, they relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program ***and*** not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction.[20] In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, 42 C.F.R. § 412.106(b)(4) (2019) states in pertinent part:

> (4)*Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act**.
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Because the Provider did not raise the Section 1115 waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The Medicaid eligible days issue as stated in the original appeal request cannot be construed to include Section 1115 waiver days. Additionally, there is no indication that any Section 1115 waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

---

[33] 65 FR 47054, 47087 (Aug. 1, 2000).

Regardless, even if the Provider had included the Section 1115 waiver days issue in its appeal request (which it did not), the Provider failed to properly develop the issue in its PPP filing. The Provider's PPP does not identify the specific 1115 waiver day program(s) at issue) notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Dec. 2023). Pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* Section 1115 waiver days sub-issue.

The Board's finding that neither the appeal request nor the PPP met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[34] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[35] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[36] The Court found that this description of the issue was a violation of Board rules and a proper basis for the Board to dismiss the appeal.[37] Here, the Board makes the same finding based on similar *overly generalized language*.

Based on the above, the Board finds that ***the appeal did not include the alleged Section 1115 waiver days sub-issue*** consistent with 42 C.F.R. §§ 405.1835(b)(2)-(3), 412.106(b)(4)(iii), and 405.1871(a)(3) and Board Rules 7.1, 8, 25, and 27.2.[38] Further, the Board finds that the issue was not properly developed in the PPP process.

* * * *

Based on the foregoing, the Board is ***dismissing the SSI Provider Specific and Medicaid Eligible Days/Section 1115 Waiver Days issues*** in this case. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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[34] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[35] *Id*. at *11.
[36] *Id.*
[37] *Id.*
[38] If section 1115 waiver days were found to be part of the appeal request and had been properly briefed, the Board would still need to address an additional jurisdictional issue – review whether it had jurisdiction over the section 1115 waiver days. For example, the Board has found that when a class of days (*e.g.*, 1115 waiver days) is excluded due to choice, error, and/or advertence from the as-filed cost report, then that class of days is an unclaimed cost for which the Board would lack jurisdiction under 42 U.S.C. § 1395oo(a). *See, e.g.,* PRRB Jurisdictional Decision, Case Nos. 06-1851, 061852 (Nov. 17, 2017) (dismissing the class of adolescent psychiatric days from the appeal because no days were claimed with the as-filed cost report due to choice, error and/or inadvertence and, as such, the practical impediment standard or futility concept in the *Norwalk* and *Danbury* Board decisions is not applicable).

Board Members:

Kevin D. Smith, CPA
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Nicole E. Musgrave, Esq.
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For the Board:

9/30/2026

X Nicole E. Musgrave

Nicole E. Musgrave, Esq.
Board Member
Signed by: Nicole Musgrave-burdette -S

cc: Byron Lamprecht, WPS Government Health Admin. (J-5)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran, President
Quality Reimbursement Services, Inc.
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RE: ***Board Decision – Dismissal of DSH Payment/SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues***
Jefferson Memorial Hospital (Provider Number 44-0056)
Fiscal Year Ended: 09/30/2018
Case Number: 23-1158

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-1158. Set forth below is the background of the case and the Board's decision related to the issues challenging the SSI-Provider Specific and Medicaid Eligible Days issues.

Background:

A. *Procedural History for Case No. 23-1158*

On **September 28, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2018.

On **March 17, 2023**, Community Health Systems ("CHS") filed an appeal on behalf of the Provider. The Appeal Request included five (5) issues:

1. DSH Pymt/SSI % (Provider Specific)
2. DSH/SSI - Unduly Narrow Definition of SSI Entitlement[1]
3. DSH Pymt - Medicaid Eligible Days
4. Medicare Managed Care Part C - SSI & Medicaid Fractions[2]
5. Dual Eligible Days - SSI and Medicaid Fractions[3]

The Provider is commonly owned by CHS, so it is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1).

On **March 20, 2023**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates ("ACDD"), providing among other things, the filing deadlines for the parties' preliminary position

[1] On October 11, 2023, CHS transferred this issue to an SSI Systemic Errors CIRP Group, Case No. 21-1206GC. On August 7, 2026, the Board subsequently denied the transfer because it determined the issues were not the same. On August 8, 2026, QRS transferred the issue to a new Unduly Narrow CIRP group under Case No. 26-2711GC.
[2] On October 11, 2023, this issue was transferred to Case No. 20-2149GC.
[3] On October 11, 2023, this issue was transferred to Case No. 21-0066GC.

papers ("PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R.
> § 405.1853. See Board Rule 25.[4]

On **November 13, 2023**, CHS filed the Provider's PPP.

On **January 8, 2024,** CHS filed a change in representation to Quality Reimbursement Services, Inc. ("QRS") which the Board acknowledged the same day.

On **January 15, 2024**, the Medicare Contractor ("MAC") filed a jurisdictional challenge.

On **February 19, 2024,** the Medicare Contractor filed its PPP.

On **February 27, 2024**, the Medicare Contractor filed a substantive claim challenge.

On **August 4, 2026**, the case was scheduled for a hearing on **February 19, 2027**.

B. Description of Issue 1 in the Appeal Request

In its Individual Appeal Request, the Provider summarizes its SSI Percentage (Provider Specific) issue as follows:

> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed cause [sic] CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).

[4] (Emphasis added.)

> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[5]

On November 13, 2023, the Board received the Provider's PPP in Case No. 23-1158. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' [sic] SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[6]

The amount in controversy listed for Issue 1 and Issue 2 in the Provider's individual appeal request is the same, $8,894, for each issue respectively.

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[5] Issue Statement at 1.
[6] Provider's PPP at 8-9.

Description of Issue 3 in the Appeal Request

In its Individual Appeal Request, the Provider questions whether the MAC properly excluded Medicaid eligible days from the DSH calculation. The Statement of the Legal Basis is as follows:

> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.

The estimated reimbursement amount for this issue is $29,583.[7]

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[8] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[9]

The Provider then, for the first time in this appeal, states that it is seeking reimbursement for section 1115 waiver days as a part of the Medicaid eligible day issue. Specifically, the Provider states:

> [M]edicaid eligible days (including section 1115 waiver days), which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover to the MAC, including Section 1115 Waiver Days, (the redacted listing is attached), the Provider contends that the

[7] Issue Statement at 3.
[8] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[9] Provider's PPP at 9.

> total number of days reflected in its 2018 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.
>
> With respect to section 1115 waiver days, the courts have firmly rejected CMS's interpretation of its regulations, holding instead that the plain language of the statute and the regulations require inclusion in the Medicaid Fraction of the days belonging to individuals who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool. *See Forrest General Hospital,* 926 F.3d 221 (5th Cir. 2019); *HealthAlliance Hospitals, Inc. v. Azar*, 346 F. Supp. 3d 43(D.D.C. 2018); *Bethesda Health Inc., v. Azar*, 389 F. Supp. 3d 32, (D.D.C. 2019), *aff'd*, 980 F.3d 121 (D.C. Cir. 2020). CMS has acquiesced in *Bethesda* and is now following the statute and the plain meaning of its own regulations (which regulations represent the official policy of CMS all along). *See* CMS Manual Instructions System, Change Request 12669, Transmittal No. 11912 (March 16, 2023) ("Transmittal 11912"), attached as Exhibit P-4.[10]

MAC's Contentions: Issue 1 – DSH SSI Provider Specific:

In its jurisdictional challenge, the MAC argues that the Board lacks jurisdiction over the SSI-Provider Specific issue, which has three components: "1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment."[11] The MAC contends that the third sub-issue should be dismissed because it is duplicative of the SSI issue under appeal in the CIRP group. The component related to SSI realignment should be dismissed because it was not briefed in the PPP, and thus, has been abandoned, and should be considered withdrawn, as per Board Rule 25.3. In addition, the Provider's cost report year end is identical to the federal fiscal year end (9/30) so there would be no change based on a realignment request. Finally, the MAC asserts the SSI Provider Specific issue should be dismissed because the Provider did not file a complete PPP in accordance with 42 C.F.R. § 405.1853 and Board Rule 25.[12]

MAC's Contentions: Issue 3 – DSH Medicaid Eligible Days:

The MAC also argues the Board lacks jurisdiction over the Medicaid Eligible Days issue. The MAC contends that the Provider failed to include a list of additional Medicaid eligible days they expect to be included with their appeal or their PPP, even though the Provider advised that it would send a listing of additional Medicaid eligible days under separate cover.[13] The MAC also challenges the Provider's attempt to untimely add the Section 1115 Waiver Days issue by including it in the narrative of the PPP.[14]

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[10] *Id.* at 9-10.
[11] Medicare Contractor's Jurisdictional Challenge at 2 (Jan. 15, 2024).
[12] *Id.*
[13] *Id.* at 10.
[14] *Id.* at 13.

Provider's Jurisdictional Response:

Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."[15] The Provider failed to file a timely response by the *February 14, 2024* deadline.

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby dismisses the Provider's Issue Nos. 1 and 3.

A. SSI Percentage (Provider Specific)

The analysis for Issue No. 1 has three relevant aspects to consider: (1) individuals who are eligible for SSI but did not receive SSI payment; (2) data accuracy and (3) SSI realignment.

1. First Aspect of Issue 1

The aspect of Issue No. 1 related to the Provider's disagreement with how the MAC computed the SSI percentage because of CMS' policy of excluding patients that were entitled to SSI from the numerator of the Medicare fraction—is duplicative of the Unduly Narrow Definition of SSI Entitlement issue that is being pursued as Issue #2.

The SSI-Provider Specific issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[16] Per the appeal request, the Provider's legal basis for its SSI Percentage (Provider Specific) issue asserts that the MAC "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[17] The Provider argues that "its'[sic] SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's

[15] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[16] Issue Statement at 1.
[17] *Id.*

Regulations."[18] Finally, the Provider argues that CMS inconsistently interprets the term "entitled" as used in the statute because it requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator, saying "CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment."[19] These arguments are restated in Issue No. 2 where the Provider points to CMS' policy of applying different interpretations to the term "entitled."[20]

The Board finds that aspect of the issue related to the term "entitled" in Case No. 23-1158 is duplicative of the Unduly Narrow issue described at Issue No. 2, which was subsequently transferred to a CIRP group, Case No. 26-2711GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6,[21] the Board dismisses this aspect of the SSI-Provider Specific issue.

2. Second Aspect of Issue 1

With regard to the data accuracy aspect of the issue, the Board finds that the Provider's PPP failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of any alleged "errors" in its PPP and include *all* exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents**[22]
>
> If documents necessary to support your position are still unavailable, then provider the following information in the position papers:
>
> 1. *Identify* the missing documents;
> 2. *Explain why* the documents remain unavailable;
> 3. *State the efforts* made to obtain the documents; *and*
> 4. #*xplain when* the documents will be available.

[18] *Id.*
[19] *Id.*
[20] Issue Statement at 2.
[21] Board Rules v. 3.1 (Nov. 2021).
[22] Board Rules v. 3.1 (Nov. 2021)

> Once the documents become available, promptly forward them to the Board and the opposing party.[23]

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule:

> Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MEDPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year.[24]

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[25]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting for, nor does it identify the claims to which it should have access or why this is not a common issue already covered by the CIRP group.

Additionally, in its PPP, the Provider states, "[t]he [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief

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[23] (Italics and underline emphasis added.)
[24] 70 Fed. Reg. 47278, 47438 (Aug. 12, 2005) (bold and italics emphasis added).
[25] Last updated Sept. 28, 2026.

included as Exhibit P-3)."[26] The Board finds that this incorporation by reference does not comply with the regulatory and Board rule requirements to *fully* develop the Provider's position in the PPP. Particularly 42 C.F.R. § 405.1853 provides, in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[27]

An incorporation of arguments by reference from a different case simply fails to do so. Accordingly, the Board dismisses that portion of the issue as well.

3. Third Aspect of Issue 1

The aspect of the SSI Percentage (Provider Specific) issue related to the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period is also dismissed by the Board.

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Moreover, without this written request, the MAC cannot issue a final determination with which the Provider can be dissatisfied for Board appeal purposes. There is nothing in the record to indicate the MAC has made a final determination regarding DSH SSI Percentage realignment. Additionally, the Provider failed to brief the issue in its PPP, violating Board Rules 23 & 25. Finally, the Board concurs with the MAC that the Provider's cost report and the federal fiscal year end are the same. Therefore, there would be no change based on a request for realignment. In accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses the Realignment aspect of the appeal.

B. DSH Payment – Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider's issue statement for Issue 3 is stated, *supra*.

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days that affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) (2018), which places the burden of production on the provider states, in pertinent part:

> The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this

[26] Provider's PPP at 8-9.
[27] (Emphasis added).

> paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) (2018) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Availability of Issue-Related Information and Basis of Dissatisfaction)[28] states:

> The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal consistent with 42 C.F.R. § 405.1835(b) or (d) as applicable. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

Furthermore, 42 C.F.R. § 405.1853(b) addresses position papers and specifies, in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[29]

Similarly, Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[30] This requirement is consistent with

[28] Board Rules v. 3.1 (Nov. 2021).
[29] (Emphasis added).
[30] (Emphasis added).

42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides instruction on the content of position papers as it relates to unavailable documentation/exhibits, as discussed *supra*.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's ***own motion***:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned;
- upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868);
- if the Board is unable to contact the provider or representative at the last known address; or
- upon failure to appear for a scheduled hearing.

Relative to a Medicaid Eligible Days determination, it is well-established that adequate data to prove eligibility for each Medicaid patient day claimed is a complete and accurate (*i.e.*, auditable) Medicaid eligible days listing, which, upon timely submission by a provider, a Medicare Contractor can examine to make applicable adjustments.

This appeal was initiated on March 17, 2023 (more than 3.5 years ago), and at that time, the Provider did not include a list of the additional Medicaid eligible days they expected to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Provider's PPP indicated that it would be sending the eligibility listing under separate cover.[31] ***To date, the Medicare Contractor has not been provided an auditable listing.*** Accordingly, the Provider has abandoned the issue by failing to properly develop its arguments and provide supporting documents, and by failing to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[32] Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.

C. 1115 Waiver Days

The Board finds that the Section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the Section 1115 Waiver days.

The regulations in effect when this appeal was filed with the Board in March of 2023 required the following:

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[31] Provider's PPP at 10.

[32] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing in the manner prescribed by the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.[33]

Board Rule 7.2.1 elaborated on this regulatory requirement, instructing providers:

The following information and supporting documentation must be submitted for each issue raised in the appeal request.

- An issue title and a concise issue statement describing:
  - the relevant adjustment(s), including the adjustment number(s),
  - the controlling authority (*e.g.*, specific regulation, Federal Register issuance, manual provision, or Ruling),
  - why the adjustment(s) is incorrect,
  - how the payment should be determined differently,
  - the reimbursement effect, and
  - the basis for jurisdiction before the Board.

Board Rule 8 explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…." The Rule continues:

> Several examples are identified below, but these examples are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[34]

Effective August 21, 2008, following the appropriate notice and comment period, new Board

[33] 42 C.F.R. § 405.1835(b).
[34] (Bold and italic emphasis added).

regulations went into effect that limited the addition of issues to appeals.[35]

42 C.F.R. § 405.1835(e) provides, in relevant part:

> (e) Adding issues to the hearing request. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
> . . .
>
> (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

In practice, this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider added the Section 1115 Waiver days to the case properly or timely.

In this regard, the Board notes that Section 1115 Waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[36] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) (2018) states, in pertinent part:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

[35] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[36] 65 FR 47054, 47087 (Aug. 1, 2000).

> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.**
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for **each** Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Because the Provider did not raise the Section 1115 Waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The DSH Medicaid Eligible Days issue as stated in the original appeal request cannot be construed to include Section 1115 Waiver days. Additionally, there is no indication that any 1115 Waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

Regardless, even if the Provider had included in its appeal request (***which it did not***), the Provider failed to properly develop the issue in its PPP filing as it does not identify the specific 1115 waiver day program(s) at issue). In addition, the PPP does not discuss whether or not the Section 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(4)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the PPP is perfunctory in that it only makes cursory conclusions.[37] Again, the Provider failed to so develop its PPP, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 23 (Nov. 2021).

As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* Section 1115 waiver days sub-issue.

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[37] For example, CHS cites to *Forrest General Hosp.*, 926 F.3d 221 (5th Cir. 2019) for the proposition that "the plain language of the statute and regulations require inclusion in the Medicaid Fraction of the days belong to individual who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool." However, CHS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is CHS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? CHS fails to brief the merits of its claims and fails to establish the Board's jurisdiction over the § 1115 waiver day issue as required by 42 C.F.R. § 405.1853(b)(2). Indeed, the quoted sentence is the only time the PPP references "uncompensated care pool."

The Board's finding that neither the appeal request nor the PPP met the Board content requirements is consistent with the ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[38] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[39] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[40] The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[41] Here, the Board makes the same finding based on similarly *overly generalized language.*

****

Based on the foregoing, the Board is dismissing the SSI - Provider Specific - Issue No.1 and Medicaid Eligible Days (*including Section 1115 Waiver Days*)- Issue No. 3, in their entirety, from this case.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.
Clayton J. Nix, Esq.

For the Board:

9/30/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: KEVIN D. SMITH -A

cc: Cecile Huggins, Palmetto GBA (J-J)
Wilson C. Leong, Esq., Federal Specialized Services

[38] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[39] *Id*. at *5.
[40] *Id.*
[41] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran, President
Quality Reimbursement Services, Inc.
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RE: ***Notice of Dismissal***
Case No. 25-1112 – Princeton Community Hospital (Prov. No. 51-0046), FYE 6/30/2021

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 25-1112. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's SSI Provider Specific issue.

Background:

A. *Procedural History for Case No. 25-1112*

On **June 26, 2024**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2021. The Provider is commonly owned by West Virginia University Health System ("WVU Medicine").

On **December 19, 2024**, Quality Reimbursement Services, Inc. ("QRS") filed the Provider's individual appeal request which included nine (9) issues:

1. SSI - Provider Specific
2. SSI - Unduly Narrow Definition of SSI Entitlement[1]
3. Medicaid Eligible Days[2]
4. SSI MCD PT C[3]
5. Improper Rulemaking-SSI Medicare Fraction Dual Eligible Days[4]
6. Improper Rulemaking-Medicaid Medicare Fraction Dual Eligible Days[5]
7. Standardized Payment Amount[6]
8. Medicare Crossover Bad Debts[7]
9. Reasonable Cost to IPPS Budget Neutrality Adjustment[8]

As the Provider is commonly owned/controlled by WVU Medicine, it is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1).

[1] On July 3, 2025, this issue was transferred to Case No. 25-4915GC.
[2] On August 14, 2025, this issue was withdrawn.
[3] On July 3, 2025, this issue was transferred to Case No. 25-4916GC.
[4] On July 3, 2025, this issue was transferred to Case No. 25-4917GC.
[5] On July 3, 2025, this issue was transferred to Case No. 25-4918GC.
[6] On December 15, 2025, this issue was transferred to Case No.26-0743GC.
[7] On July 3, 2025, this issue was transferred to Case No. 25-4919GC.
[8] On July 3, 2025, this issue was transferred to Case No. 25-4920GC.

On **December 20, 2024**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter* "PPP").

On **August 14, 2025**, the Provider timely filed its PPP, followed by the Medicare Contractor's ("MAC") PPP on **November 6, 2025**.

On **November 24, 2025**, the MAC filed a jurisdictional challenge. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

B. Description of Issue 1 in the Individual Appeal Request and the Provider's Participation in Case No. 24-4915GC

In its Individual Appeal Request, the Provider summarizes its DSH- SSI Provider Specific issue as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[9]

On July 3, 2025, the Provider transferred its Unduly Narrow Definition of SSI Entitlement issue (No. 2) to the "WVU Medicine CY 2021 DSH SSI Unduly Narrow Definition of SSI Entitlement CIRP Group." The group issue statement in Case No. 25-4915GC includes the following excerpts:

[9] Issue Statement at 1.

> The Provider(s) protest(s) CMS's policy of excluding unpaid SSI days from the numerator of the Medicare fraction. Despite CMS's seemingly contrary policy of treating unpaid Part A days as days entitled to benefits under Part A, CMS requires that a beneficiary be paid SSI benefits (or "covered" by SSI) during the period of his or her hospital stay in order for such days to be considered "entitled to supplemental security income benefits" and included in the numerator of the SSI fraction.
>
> * * *
>
> CMS's policy of applying different interpretations to the same term, "entitled," used in the same sentence of the statute is the epitome of arbitrary and capricious agency action and must be reversed. *See Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 20 n.1 (D.C. Cir. 2011) (Kavanaugh, J., concurring) ("HHS thus interprets the word 'entitled' differently within the same sentence of the statute. The only thing that unifies the Government's inconsistent definitions of this term is its apparent policy of paying out as little money as possible. I appreciate the desire for frugality, but not in derogation of law."); *see also Walter O. Boswell Mem'l Hosp. v. Heckler*, 749 F.2d 788, 799 (D.C. Cir. 1984) ("It would be arbitrary and capricious for [the Secretary] to bring varying interpretations of the statute to bear, depending upon whether the result helps or hurts Medicare's balance sheets….").
>
> * * *
>
> Because CMS's treatment of unpaid Part A days as "days entitled to benefits under part A" was upheld by the Supreme Court in *Becerra v. Empire Health* Found., for Valley Hosp. Med. Ctr., 597 S.Ct. June 24, 2022 WL 227680 (2022), CMS must apply the same interpretation of the word "entitled" in the context of "entitled to supplemental security income benefits." By doing so, CMS will necessarily have to widen the number of SSI status codes it treats as being "entitled to SSI benefits" to encompass not just the three codes CMS currently includes, but all codes that reflect *eligibility* for SSI benefits.[10]

On August 14, 2025, the Board received the Provider's preliminary position paper ("PPP") for Case No. 25-1112. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.

[10] Group Issue Statement, Case No. 25-4915GC.

> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra….[11]

MAC's Contentions: Issue 1 – SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the SSI Percentage (Provider Specific) issue, which has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the portion of the issue related to individuals who are eligible for SSI but did not receive payment should be dismissed because it is duplicative of the issue in CIRP Group, Case No. 25-4915GC. With regard to the portion of the issue related to SSI realignment, the MAC argues this component should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies. Finally, the MAC asserts that the Provider failed to file a complete PPP with a fully developed narrative, including all exhibits, or alternatively, explain its efforts to obtain documents which are missing in accordance with Board Rule 25.2.2. For these reasons, the MAC requests dismissal of the SSI Percentage (Provider Specific) issue.[12]

Provider's Jurisdictional Response: Issue 1- SSI Percentage (Provider Specific)

Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed on *December 24, 2025*.

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more

[11] Provider's PPP at 11-12.
[12] MAC's Jurisdictional Challenge at 2.

(or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

For the reasons set forth below, the Board hereby dismisses the Provider's Issue No. 1, SSI Percentage (Provider Specific). The analysis for Issue No. 1 has three relevant aspects to consider: (1) individuals who are eligible for SSI but did not receive SSI payment; (2) data accuracy and (3) SSI realignment.

1. First Aspect of Issue 1

The aspect of Issue No. 1 related to the Provider's disagreement with how the MAC computed the SSI percentage because of CMS' policy of excluding patients that were entitled to SSI from the numerator of the Medicare fraction—is duplicative of the Unduly Narrow Definition of SSI Entitlement issue that is being pursued in the "WVU Medicine CY 2021 DSH SSI Unduly Narrow Definition of SSI Entitlement CIRP Group," Case No. 25-4915GC. As shown above, the individual appeal and the group appeal both contend that CMS inconsistently interprets the term "entitled" as it is used in the statute.

Because this aspect of the issue related to the term "entitled" in Case No. 25-1112 is duplicative of the Unduly Narrow issue described in the CIRP Group, Case No. 25-4915GC and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6, the Board dismisses this aspect of the SSI - Provider Specific issue.

2. *Second Aspect of Issue 1*

With regard to the data accuracy component of the issue, the Board finds that the Provider's PPP failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of any alleged "errors" in its PPP and include *all* exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents (Nov. 2021)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[13]

The Provider cites to the 2000 Federal Register, but additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have occurred since then. For example, as noted in the FY 2006 IPPS Final Rule:

[13] (Italics and underline emphasis added.)

> Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MEDPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[14]

3. Third Aspect of Issue 1

The third aspect of the SSI Percentage (Provider Specific) issue is the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the MAC cannot issue a final determination with which the Provider can be dissatisfied for Board appeal purposes. There is nothing in the record to indicate the MAC has made a final determination regarding DSH SSI Percentage realignment.

Further, the Board finds that the Provider did not brief this issue within its PPP. Board Rule Rule 25.3 addresses issues that are not briefed in a provider's PP. In relevant part, this rule states: Any issue appealed, but not briefed by the Provider in its PP will be considered withdrawn. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the issue.

****

Based on the foregoing, the Board is dismissing the last remaining issue in this case: DSH Payment SSI Percentage (Provider Specific) - Issue No. 1. As no issues remain, the Board hereby closes Case No. 25-1112 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

[14] Last updated Sept. 28, 2026.

Board Members Participating:

Kevin D. Smith, CPA
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Nicole E. Musgrave, Esq.
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For the Board:

9/30/2026

X Nicole E. Musgrave

Nicole E. Musgrave, Esq.
Board Member
Signed by: Nicole Musgrave-burdette -S

cc: Dana Johnson, Palmetto GBA c/o Wellpoint Federal Solutions (J-M)
Wilson C. Leong, Esq., Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran, President
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RE: ***Board Determination – Dismissal of Group for Insufficient Representation Letter and Duplication of Providers***

Central Florida Health CY 2024 ATRA IPPS Payment Reduction CIRP Group[1]
Case Number: 24-1556GC

Univ of Florida Health FFY 2024 ATRA/MACRA .9412% Adjustment CIRP Group
Case Number: 24-1655GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the "Board") has reviewed the Central Florida Health CY 2024 ATRA IPPS Payment Reduction CIRP Group which was filed by Quality Reimbursement Services, Inc. ("QRS") and has identified several impediments. The pertinent facts and the Board's Determination are set forth below.

Pertinent Facts:

On **February 24, 2024** QRS field the "Central Florida Health ***CY 2024*** ATRA IPPS Payment Reduction CIRP Group" under Case No. 24-1556GC.[2] The group was filed from the August 28, 2023 Federal Register and included two participants at formation:

- UF Health Leesburg Hospital (Provider Number 10-0084) and
- The Villages Regional Hospital (Provider Number 10-0290).

The Representation letter submitted on behalf of both Providers was dated **February 5, 2018** (six years prior to the group being filed) and was signed by Diane Harden of Central Florida Health.[3] The Representation letter authorized QRS to handle the appeal of Federal fiscal year ("FFY") ***2018, and cited to the August 14, 2017 Federal Register***.

[1] University of Florida Health (Univ of Florida Health) acquired Central Florida Health in January 2020.
[2] Although the group was identified as a calendar year ("CY") group, since it was filed from a Federal Register, it should have been identified as a Federal fiscal year ("FFY") group.
[3] An internet search shows Ms. Harden held her executive role at Central Florida Health through May 2021 – and left three years prior to this appeal being filed.

On **February 26, 2024**, Hall, Render, Killian, Heath & Lyman, P.C. ("Hall Render") filed the "Univ of Florida Health FFY 2024 ATRA/MACRA .9412% Adjustment CIRP Group" under Case No. 24-1655GC. The group was also filed from the August 28, 2023 Federal Register. On the same day, Hall Render filed requests to directly add two more providers to the group (the same two Providers as in the QRS group):

- UF Health Leesburg Hospital (10-0084) and
- The Villages Regional Hospital (10-0290).

Hall Render's Representation letter fowas signed by Yvette Hayes of University of Florida Health and was dated **February 26, 2024**. The Representation letter authorized Hall Render for the ***FFY 2024*** ATRA MACRA Understatement issue.

On **February 28, 2024**, Hall Render transferred one additional provider to Case No. 24-1655GC from an optional group, Case 24-1490G: Shands Jacksonville (Prov. No. 10-0001).

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final contractor determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

When a Representative files an appeal for a provider (whether it be an individual appeal or a direct addition to a group), the Representative is required to certify that it is authorized to make the filing on behalf of the provider by including a copy of the Representation Letter evidencing that authorization.[4] Requiring Representation Letters to be properly executed for the fiscal year at issue protects providers and health chains from potentially coercive or abusive representation situations, whether in the context of an individual or group appeal.

The submission of an authorization letter that was 6 years old and that did not reference the correct period under appeal leads the Board to surmise that the Providers may have been unaware of QRS' filings on its behalf. In addition, the person who signed the authorization letter filed by QRS left the parent organization 4 years before the group was filed. Therefore, QRS' group does not include a sufficient Representative Letter.

In addition, as the Parties are aware, it is the Board's policy to establish ***only*** one (1) appeal per Provider per fiscal year end.[5] In this regard, Board Rules 5.1 and 12.8 specify that there may be only one (1) representative ***per appeal*** and ***for all participating providers in a group***. Further, Board Rule 12.10 indicates that "[t]he person filing the appeal request on behalf of a group must certify the submission, specifically: . . . that the group issue filed in this appeal is not pending in

[4] Board Rules 5, 6.1.1, 6.5, 12.8, 12.10, Model Form A, Model Form E.
[5] Board Rules 4.6.1, and 5.4. *See also* 42 C.F.R. § 405.1837.

any other appeal for the same period for the same providers, nor has it been adjudicated, withdrawn, or dismissed from any other PRRB appeal."

For purposes of the Univ of Florida Health organization and its FFY 2024 appeals of the ATRA/MACRA issue, the Board can only have one CIRP group appeal for the issue and that group can only have one representative. Based on the following factors, the Board has determined that it will close QRS' group under Case No. 24-1556GC because:

1) The only two participants (UF Health Leesburg Hospital and The Villages Regional Hospital) are duplicated in Hall Render's CIRP group for the same FFY and issue under Case No. 24-1655GC; and
2) The authorization letter for QRS' group is insufficient as it was obsolete (i.e., the person that signed the letter had left the parent organization four years prior to the group formation and the letter incorrectly referenced the wrong period under appeal as CY 2018 instead of FFY 2024.)

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:
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Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.
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For the Board:

9/30/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: KEVIN D. SMITH -A

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Elizabeth Elias, Hall, Render, Killian, Heath & Lyman, P.C.
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